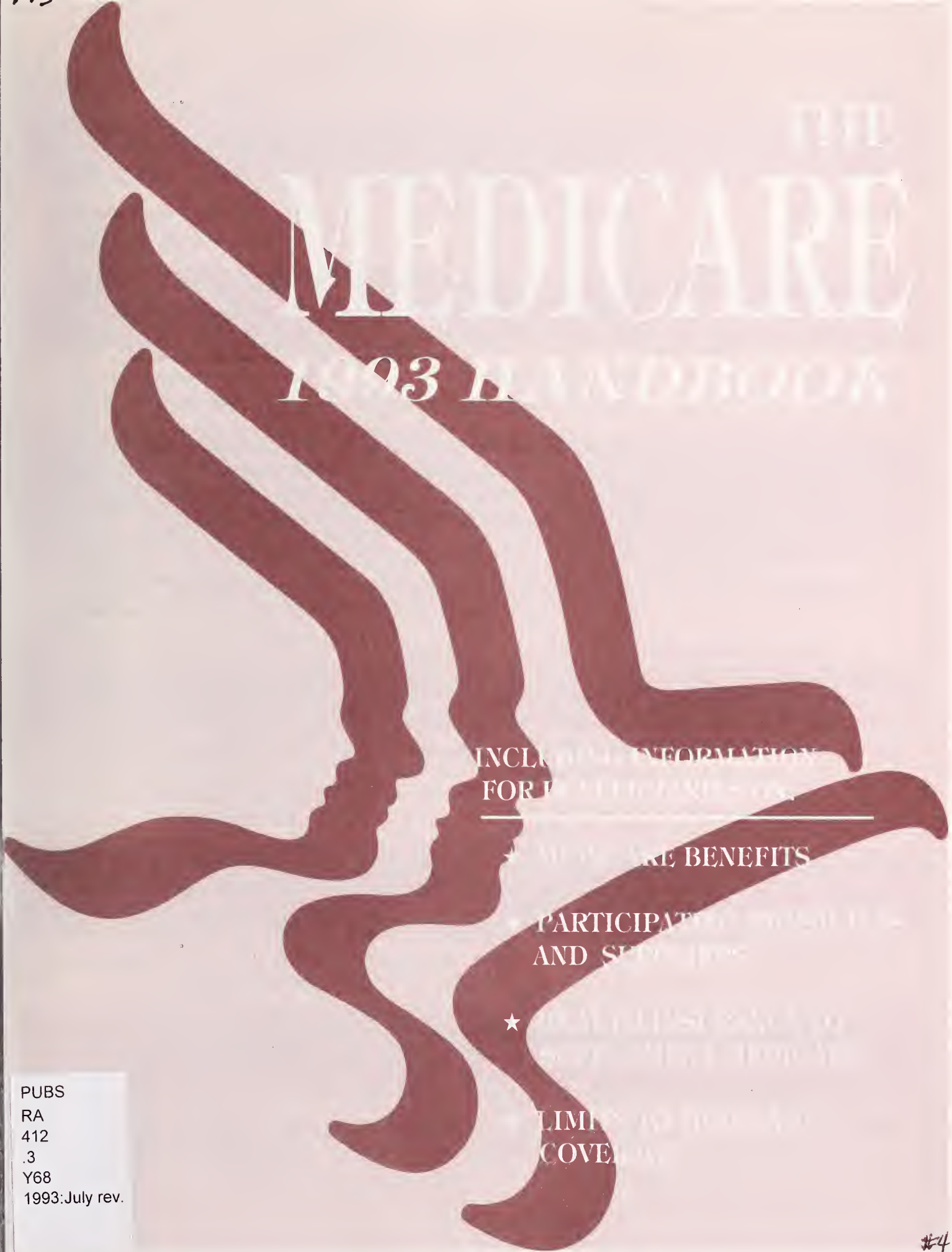

THE MEDICARE HANDBOOK

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IF YOU HAVE QUESTIONS

About	Examples	Contact
Enrollment in Medicare A and B	How do I enroll in Medicare? I lost my card, what should I do?	Social Security 1-800-772-1213
Who pays first?	I have other health insurance in addition to Medicare.	Your employer or the provider of service (see pages 10 and 11).
Part B payments	How much will Medicare pay on my last doctor bill? When will I get an explanation of Medicare benefits?	Part B carrier (listed by state on pages 39 to 44).
Doctors who take assignment on all claims	Where can I get a list of the "participating physicians" in my area?	Part B carrier (listed by state on pages 39 to 44).
Quality of care	I think I was discharged too soon from the hospital. I developed a lung infection in the hospital while I was being treated for a broken hip.	Medicare Peer Review Organization (PRO), listed by state on pages 45-49. Do **not** call the PRO about your Medicare bills.
Part A payments	I got a statement from the hospital. Will Medicare pay my whole bill?	Fiscal Intermediary (See 'Intermediaries and Carriers' on page 3.)
Buying Medigap insurance	Do I need extra insurance? How do I choose a policy?	Your state insurance department (see pages 8 and 9).
Reporting Medigap fraud	I was sold a policy that provides benefits I already have with Medicare.	Your state insurance department (see pages 8 and 9) **and** call Medicare at 1-800-638-6833.
Financial assistance	I don't have enough money to pay my Medicare premium or coinsurance. Can I get help?	Your state or local welfare, social service or public health agency (see pages 2 and 3).
Reporting Medicare fraud	I was billed for a service I did not get.	Medicare carrier or intermediary first (see page 4).
Limiting Charge	My doctor did not take assignment and billed me more than Medicare permits.	Your doctor or carrier (see page 28).
Finding an HMO	Is there an HMO in my area that contracts with Medicare?	Call the Health Care Financing Administration regional office (see page 7).

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

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Dear Medicare Beneficiary:

If you are new to the Medicare program, let me welcome you as a member of the largest health insurance program in the world! Medicare is now in its 28th year of assisting people aged 65 and older and certain disabled Americans in meeting the costs of health care. This year we expect Medicare coverage to reach more than 36 million people.

Medicare is an important resource that will help you afford the services of the most advanced medical system of any country. This booklet will help you to understand and fully benefit from the Medicare program.

If you have been a Medicare beneficiary for a while, note that new benefits have been added recently. For example, Medicare now pays for flu shots, mammography screening and Pap smear screening. There are new options for buying insurance benefits that supplement Medicare's coverage, known as "Medigap" policies. Also, there is help with premium, deductible, and copayment expenses for beneficiaries with lower incomes.

I hope you will find this booklet to be a useful reference.

Sincerely,

Donna E. Shalala

ABOUT THIS HANDBOOK

Medicare pays for many of your health care expenses, but **it does not cover all of them**. It is important for you to know what Medicare does and does not pay for. This Handbook will help you understand how the Medicare program works and what your benefits are. You can use the alphabetical index at the back of the book to find information on specific subjects. This Handbook is also available in Spanish. (See inside back cover for how to order.)

Don't Miss

❑ The Assignment Method of Payment

Many doctors and suppliers have agreed to be part of Medicare's participating physician and supplier program. They accept assignment on all Medicare claims. If you get your medical services from one of these participating doctors or suppliers, you can often save money. See page 28 for more information about the assignment method of payment, and what you can do to find a participating doctor or supplier.

❑ Your Appeal Rights

Pages 35and 36 explain how to appeal when Medicare does not pay your Part A or Part B claims.

❑ If You Need Financial Assistance to Pay for Health Care

Sometimes you can get help paying for Medicare. Look on pages 2 and 3 for more information.

❑ New primary and preventive services

Medicare now has a Federally Qualified Health Center benefit. Look on page 24.

❑ New Information About Insurance to Supplement Medicare

Some people want to have insurance to pay medical bills Medicare doesn't cover. See pages 8 and 9 to find out about Medicare supplement "Medigap" insurance, including a new open enrollment period.

❑ New Benefits

Recently added Medicare Part B benefits for cancer screening—mammograms and Pap smears—are described on page 25.

❑ Who Pays First?

Medicare is not always the insurer that pays first on claims. For example, some people are employed, or their spouse is employed, and the employer health insurance pays first. For more about who pays first, see pages 10 and 11.

❑ Where to Call or Write

Look on the inside front cover to find where to call or write to ask questions about Medicare.

This handbook is meant to explain the Medicare program, but is not a legal document. The official Medicare program provisions are contained in the relevant laws, regulations and Rulings.

New Information about Durable Medical Equipment and Supplies

New Supplier Standards

Effective October 1, 1993, suppliers of durable medical equipment and supplies have to meet strict standards to qualify for a supplier number to receive payment by Medicare. Before you purchase or rent equipment from a durable medical equipment supplier, make sure the supplier is approved by Medicare and has a Medicare supplier number. **Medicare may not pay your claim if your supplier does not have a Medicare number.**

You can find out if your supplier has a number by calling the National Supplier Clearinghouse toll-free at 1-(800)-851-3682. Or you can write to the National Supplier Clearinghouse at P.O. Box 100142, Columbia, SC 29202-3142. (The National Supplier Clearinghouse does not have any information about Medicare payments or claims.)

New Regional Carriers for Durable Medical Equipment and Supplies

Medicare is changing the way durable medical equipment claims are processed. Four new regional carriers are being established. These carriers will process nothing except claims for durable medical equipment and supplies. On October 1, 1993, suppliers in some states will begin to submit claims to the regional carriers. Claims processing from all states will be transferred to the regional carriers over a four month period. Your supplier will need your permanent address to file your claim with the appropriate regional carrier. Medicare considers your permanent residence to be the address where you intend to spend over six months of the calendar year.

During the transition period, your regular Medicare carrier (listed by state on pages 39-44) will be able to answer questions about claims for durable medical equipment or will tell you how to contact your new regional carrier.

New Durable Medical Equipment Benefit: Therapeutic Shoes

Effective May 1, 1993, Medicare helps pay for therapeutic shoes and shoe inserts for people who have severe diabetic foot disease.

The doctor who treats your diabetes must certify your need for therapeutic shoes. The shoes and inserts must be prescribed by a podiatrist and furnished by a podiatrist, orthotist, prosthetist, or pedothist.

Medicare helps pay for one pair of therapeutic shoes per calendar year and for inserts. The fitting of shoes or inserts is included in the Medicare payment for the shoes.

Save this Handbook for reference. It is revised each year and is available from Social Security, but you will not automatically get a Handbook in the mail unless there are major changes in the Medicare program.

Contents

What is Medicare? 1

The Two Parts of Medicare 1
Who Can Get Medicare Hospital Insurance (Part A)? 1
Who Can Get Medicare Medical Insurance (Part B)? 1
Buying Medicare Part A and Part B 1
Enrollment in Medicare 2
Your Medicare Card 2
Assistance for Low-Income Beneficiaries 2
Intermediaries and Carriers 3
Peer Review Organizations 3
Your Right to Decide About Your Medical Care 4
Fraud and Abuse 4
Your Rights Under the Privacy Act 5

Medicare Coordinated Care Plans 6

What Are Coordinated Care Plans? 6
Who Can Enroll in Coordinated Care Plans? 6
Joining a Coordinated Care Plan 6
Ending Enrollment in a Coordinated Care Plan 6
If You Have Problems 6

Medicare and Other Insurance 8

Buying Health Insurance to Supplement Medicare 8
When Other Insurance Pays Before Medicare 10

What Medicare Does Not Pay For 12

Custodial Care 12
Care Not Reasonable and Necessary Under Medicare Program Standards 12
Services Medicare Does Not Pay For 12
Limitation of Liability 12

Medicare Hospital Insurance (Part A) 14

What Medicare Part A Includes 14
How Medicare Pays for Part A Services 14
When You Are a Hospital Inpatient 14
Skilled Nursing Facility Care 17
Home Health Care 18
Hospice Care 19

Medicare Medical Insurance (Part B) 21

What Medicare Part B Includes 21
Deductible and Coinsurance Amounts Under Part B 21
Doctors' Services Covered by Medicare Part B 21
Second Opinion Before Surgery 22

Services of Special Practitioners 23
Outpatient Hospital Services 23
Other Services and Supplies Covered by Medicare 23
Drugs and Biologicals 26
Medicare Payments for Outpatient Treatment of Mental Illness 27

Medicare Medical Insurance (Part B) Payments 28

The Assignment Payment Method 28
Participating Doctors and Suppliers 28
When Your Doctor Does Not Accept Assignment 28
Participating Providers 29
Medicare Approved Amounts 29
Submitting Part B Claims 29

Getting the Part of Medicare You Do Not Have 33

Getting Medicare Medical Insurance (Part B) 33
Getting Medicare Hospital Insurance (Part A) 33
Special Enrollment Period 33

Events That Can Change Your Medicare Protection 34

When Protection Ends for People 65 and Older 34
When Protection Ends for the Disabled 34
When Protection Ends for Those With Permanent Kidney Failure 34

How to Appeal Medicare Decisions 35

Appealing Decisions Made by Providers of Part A Services 35
Appealing Decisions Made by Peer Review Organizations (PROs) 35
Appealing Decisions of Intermediaries on Part A Claims 35
Appealing Decisions Made by Carriers on Part B Claims 36
Appealing Decisions Made by Health Maintenance Organizations (HMOs) 36
For More Information 36

Appendices 37

Charts: Medicare Covered Services 37
Medicare Carriers 39
Medicare Peer Review Organizations (PROs) 45

Index 50

What is Medicare?

The Medicare program is a federal health insurance program for people 65 or older and certain disabled people. It is run by the Health Care Financing Administration of the U.S. Department of Health and Human Services. Social Security Administration offices across the country take applications for Medicare and provide general information about the program.

The Two Parts of Medicare

There are two parts to the Medicare program. **Hospital Insurance (Part A)** helps pay for inpatient hospital care, inpatient care in a skilled nursing facility, home health care and hospice care. **Medical Insurance (Part B)** helps pay for doctors' services, outpatient hospital services, durable medical equipment, and a number of other medical services and supplies that are not covered by the Hospital Insurance part of Medicare. Throughout this handbook, Medicare Hospital Insurance is called Part A and Medicare Medical Insurance is called Part B.

Part A has deductibles and coinsurance, but most people do not have to pay premiums for Part A (see page 33). Part B has premiums, deductibles, and coinsurance amounts that you must pay yourself or through coverage by another insurance plan. Premium, deductible and coinsurance amounts are set each year based on formulas established by law. New payment amounts begin each January 1. When amounts increase, you will be notified. For 1993 deductible, premium and coinsurance amounts, see the charts on pages 37 and 38.

Who Can Get Medicare Hospital Insurance (Part A)?

Generally, people age 65 and older can get premium-free Medicare Part A benefits, based on their own or their spouses' employment. (Premium-free means there are no premium payments. Most people do not pay premiums for Medicare Part A.) You can get premium-free Medicare Part A if you are 65 or older and any of these three statements is true:

- You receive benefits under the Social Security or Railroad Retirement system.
- You could receive benefits under Social Security or the Railroad Retirement system but have not filed for them.
- You or your spouse had Medicare-covered government employment.

If you are under 65, you can get premium-free Medicare Part A benefits if you have been a disabled beneficiary under Social Security or the Railroad Retirement Board for more than 24 months.

Certain government employees and certain members of their families can also get Medicare when they are disabled for more than 29 months. They should apply at the Social Security Administration office as soon as they become disabled.

Or, you may be able to get premium-free Medicare Part A benefits if you receive continuing dialysis for permanent kidney failure or if you have had a kidney transplant. (People who can get Medicare because of kidney disease may get a copy of *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services* from the Consumer Information Center. See inside back cover for how to order.)

Check with Social Security to see if you have worked long enough under Social Security, Railroad Retirement, as a government employee, or a combination of these systems to be able to get Medicare Part A benefits. Generally, if either you or your spouse worked for 10 years, you will be able to get premium-free Medicare Part A benefits.

Who Can Get Medicare Medical Insurance (Part B)?

Any person who can get premium-free Medicare Part A benefits based on work as described above can enroll for Part B, pay the monthly Part B premiums (in 1993, $36.60 for most beneficiaries), and get Part B benefits. In addition, most United States residents age 65 or over can enroll in Part B.

Buying Medicare Part A and Part B

If you or your spouse do not have enough work credits to be able to get Medicare Part A benefits and you are 65 or over, you may be able to buy Medicare Parts A and B—or just Medicare Part B—by paying monthly premiums. Also, you may be able to buy Medicare Parts A and B if you are disabled and lost your premium-free

Part A solely because you are working. (See page 34 for more information.)

Enrollment in Medicare

If you are already getting Social Security or Railroad Retirement benefit payments when you turn 65, you will automatically get a Medicare card in the mail. The card will show that you can get both Medicare Hospital Insurance (Part A) and Medical Insurance (Part B) benefits. If you do not want Part B, follow the instructions that come with the card.

The above process also applies when you have been a disability beneficiary under Social Security or Railroad Retirement for 24 months. A Medicare card will come in the mail.

Some people do not automatically get a Medicare card. They must file an application to get Medicare benefits. If you have not applied for Social Security or Railroad Retirement benefits, or if government employment is involved, or if you have kidney disease, you must file an application for Medicare. Check with Social Security if you are able to get Medicare under the Social Security system or based on Medicare-covered government employment; check with the Railroad Retirement office if you are able to get Medicare under the Railroad Retirement system.

If you must file an application for Medicare, you should apply during your initial enrollment period, to avoid late enrollment penalties under Medicare Part B (unless you qualify for a special enrollment period as described on page 33). Your initial enrollment period is a seven-month period that starts three months before the month you first meet the requirements for Medicare. If you do not sign up for Medicare during the first three months of your initial enrollment period, there will be a delay in starting your Part B coverage. Your coverage will be delayed from one to three months after enrollment.

If you do not enroll for Medicare Part B **at any time** during your initial enrollment period, you will not have another chance to enroll until the next general enrollment period. A general enrollment period is held each year from January 1 through March 31 and if you enroll during this period you will not be able to get Medicare until July of that year. You may also be charged a premium penalty for late enrollment (unless you qualify for a special enrollment period as described on page 33).

The enrollment period requirements and penalties for late enrollment described above for Part B also apply to people who buy Part A. (See page 33 for more information about buying Medicare Part A.)

Your Medicare Card

The Medicare card shows the Medicare coverage you have—Hospital Insurance (Part A), Medical Insurance (Part B), or both—and the date your protection started. If you do not have both parts of Medicare, see page 33 for information on how you can get the part you don't have.

Your Medicare card also shows your health insurance claim number. Sometimes this claim number is referred to as your Medicare number. The claim number usually has nine digits and one or two letters. There may also be another number after the letter. Your full claim number must always be included on all Medicare claims and correspondence. When a husband and wife both have Medicare, each receives a separate card and claim number. Each spouse must use the exact name and claim number shown on his or her card.

It is important that you remember to:

- Use your Medicare card only after the effective date shown on it.
- Keep your card handy. And be sure to carry your card with you whenever you are away from home.
- Always show your Medicare card when you receive services that Medicare helps pay for.
- Always write your complete health insurance claim number (including any letters) on all checks for Medicare premium payments or any correspondence about Medicare. Also, you should have your Medicare card available when you make a telephone inquiry.
- Immediately ask Social Security to get you a new card if you lose yours.
- Never let anyone else use your Medicare card.

Assistance for Low-Income Beneficiaries

Federal law requires that state Medicaid programs pay Medicare costs for certain elderly and disabled people with low incomes and very limited resources, described below. The following is a general description only; rules may vary from state to state.

Qualified Medicare Beneficiaries (QMB)

In general, you must meet these requirements:

- You must be entitled to Medicare Hospital Insurance (Part A).
- Your annual income for 1992 must be at or below $7,050 for one person and $9,430 for a family of two (amounts are somewhat higher in Alaska and Hawaii).* Amounts for 1993 will be slightly higher than those for 1992.
- You cannot have resources such as bank accounts or stocks and bonds worth more than $4,000 for an individual or $6,000 for a couple. Your personal home, automobile, burial plot, furniture, jewelry, or life insurance are not counted, unless those items are of extraordinary value.

If you qualify as a QMB, your Medicare premiums, deductibles and coinsurance will be covered.

Specified Low-income Medicare Beneficiaries (SLMB)

Beginning January 1, 1993, there is a new program for certain low-income Medicare beneficiaries whose income is above the level to qualify as a QMB, but whose income is below 110 percent of the national poverty guidelines. If you qualify as a SLMB, Medicaid will pay your Medicare Part B premium only ($36.60 per month in 1993).

Where to Apply

If you think you may qualify for any of these benefits, you should file an application at the state or local welfare, social service or public health agency that serves people on Medicaid. **All of these agencies are state—not federal—agencies.**

If you need the telephone number for Medicaid, call 1-800-638-6833. Give the operator the name of your state and explain that you want the Medicaid telephone number so you can get information about these benefits.

Intermediaries and Carriers

The federal government contracts with private insurance organizations called **intermediaries** and **carriers** to process claims and make Medicare payments.

Intermediaries handle inpatient and outpatient claims submitted on your behalf by hospitals, skilled nursing facilities, home health agencies, hospices and certain other providers of services.

You will not usually need to get in touch with intermediaries because Medicare pays most hospitals, skilled nursing facilities, home health agencies, hospices and other providers of services directly. But, if you have a question about your Part A bill, ask someone who works at the facility for help. If you cannot get an answer there, ask someone in the billing office at the facility to help you get in touch with the Medicare intermediary.

Carriers handle claims for services by doctors and suppliers covered under Medicare's Part B program. If you have questions about Medicare Part B claims, contact your Medicare carrier. The addresses and phone numbers of carriers are on pages 39 to 44.

If you want someone to contact Medicare for you, see "Your Rights Under the Privacy Act," (page 5) for more information.

Peer Review Organizations

Peer Review Organizations (PROs) are groups of practicing doctors and other health care professionals who are paid by the federal government to review the care given to Medicare patients. Each state has a PRO that decides, for Medicare payment purposes, whether care is reasonable, necessary, and provided in the most appropriate setting. PROs also decide whether care meets the standards of quality generally accepted by the medical profession. PROs have the authority to deny payments if care is not medically necessary or not delivered in the most appropriate setting.

PROs investigate individual patient complaints about the quality of care and respond to:

- Requests for review of notices of noncoverage issued by hospitals to beneficiaries; and
- Requests for reconsideration of PRO decisions by beneficiaries, physicians, and hospitals.

The PRO will tell you in writing if the service you got was not covered by Medicare. See page 12 for a discussion of what is not covered by Medicare.

If you are admitted to a Medicare participating hospital, you will receive *An Important Message From Medicare* which explains your rights as a hospital patient and provides the name, address and phone number of the PRO for your state. If you are not given a copy of the message, be sure to ask for one.

*This amount is based on a percentage of the national poverty guidelines plus an income disregard of $240.

If you feel that you are improperly refused admission to a hospital or that you are forced to leave the hospital too soon, ask for a written explanation of the decision. Such a written notice must fully explain how you can appeal the decision and it must give you the name, address and phone number of the PRO where your appeal or request for review can be submitted. (See page 35 for further discussion of your appeal rights under Medicare.)

Beneficiary Complaints

PROs are responsible for reviewing beneficiary complaints about the quality of care provided by inpatient hospitals, hospital outpatient departments and hospital emergency rooms; skilled nursing facilities; home health agencies; ambulatory surgical centers; and certain health maintenance organizations.

If you believe that you have received poor quality care from one of these facilities, you may complain to the PRO. The PRO will investigate written complaints from beneficiaries, or their representatives, about the quality of Medicare services received.

Your complaint must be in writing. If you wish, the PRO will help you put your complaint in writing by taking the information from you over the telephone and writing the complaint. If someone other than the PRO makes a complaint for you or on your behalf, you must give written permission for that person to represent you in the complaint.

Medicare PROs for each state are listed on pages 45 to 49.

Your Right to Decide About Your Medical Care

Under a new Medicare law, when you are admitted to a Medicare hospital or skilled nursing facility, get Medicare home health care, or enroll in a Medicare-approved hospice or health maintenance organization, **you must be given written information about your rights to make decisions about your medical care.**

Generally, you will be told about your right to accept or refuse medical or surgical treatment. You will also be told about your right to make—if you choose—an "advance directive." An advance directive contains written instructions about your choices for health care or naming someone to make those choices for you. The instructions are to be used if you are too sick or otherwise unable to talk. (The paper giving your health care choices may be called a "living will" or "a durable power of attorney for health care.")

You do not have to have an advance directive. But, if you have one you can say "yes" in advance to treatment you want if you get too sick to talk to your health care provider. You can also say "no" in advance to treatment you don't want.

Laws governing advance directives vary from state to state. Your treatment choices will depend on what is legal in your state. You can ask health care professionals in your state about the state's rules for living wills or durable powers of attorney. You can also contact your local state's attorney's office for this information.

Fraud and Abuse

Suspected Fraud Should be Reported

If you have reason to believe that a doctor, hospital, or other provider of health care services is performing unnecessary or inappropriate services, or is billing Medicare for services you did not receive, you should immediately report to the Medicare carrier or intermediary that handles your claims (see page 3).

The routine waiver of deductibles and coinsurance by doctors or suppliers of durable medical equipment is unlawful. Coinsurance and deductible payments may be waived only after careful consideration of a particular patient's financial hardship. Therefore, if a doctor or supplier offers to waive coinsurance or deductible payments, without having considered your individual circumstances or when you have not asked to have the payments waived, you should immediately report the offer to the Medicare carrier or intermediary.

Report to the Medicare Carrier or Intermediary First

Call the carrier or intermediary first when you suspect fraud. Medicare carriers and intermediaries routinely look into cases of possible fraud and will appreciate your alerting them to your case. The carrier or intermediary will need to know the exact nature of the wrongdoing you suspect, the date it occurred, and the name and address of the party involved. Have this information ready when you call. (The telephone number of the Medicare intermediary or carrier is listed on the notice explaining Medicare's decision on your Medicare claim. Medicare carriers are also listed on pages 39 to 44.)

Calling For Further Help

If the Medicare carrier or intermediary does not respond to your report of Medicare fraud or abuse, you may call the Health Care Financing Administration (HCFA) hotline at 1-800-638-6833. There is no charge to you when you call this number. The hotline operator will refer you to the appropriate staff person at a HCFA regional office.

Be prepared to tell the HCFA regional office staff person:

- The exact nature of the wrongdoing you suspect, the date it occurred, and the name and address of the party involved.
- The name and location of the Medicare intermediary or carrier you reported it to, and when you reported it.
- The name of any intermediary or carrier employee to whom you spoke and what advice that person gave you.

Your Rights Under the Privacy Act

Under the Privacy Act all federal agencies must safeguard information they collect about the people they serve.

When the Health Care Financing Administration (the agency that administers the Medicare program) asks you to fill out forms giving information about yourself to Medicare, we must:

- Explain why we are collecting the information.
- Tell you whom we plan to give it to.
- Tell you whether you must, by law, give us the information.

When you give Medicare information, the Privacy Act allows you to:

- Review your records for accuracy.
- Make corrections, if you believe there are errors.
- Know exactly what we will do with your records.

The Privacy Act also allows the government to verify the information you give us, using computer matches with other federal or state governments. If we do computer matches, we must tell you that they take place and give you a chance to protest our findings.

We include information about matches on all the forms you fill out. We also put a notice in the *Federal Register,* which is published by the federal government to notify the public of official actions. Copies are available at many libraries. (A computer data match using Medicare, Internal Revenue Service and Social Security information is discussed on page 11.)

Medicare Carriers and Intermediaries must follow Privacy Act rules: These Medicare contractors may not discuss personal information about you with your family members or others who write or telephone on your behalf unless you give the contractors written permission.

Medicare Coordinated Care Plans

What Are Coordinated Care Plans?

More and more Medicare beneficiaries are joining coordinated care plans. These coordinated care plans are prepaid, managed care plans, most of which are health maintenance organizations (HMOs) or competitive medical plans (CMPs). Both HMOs and CMPs contract with Medicare and follow the same contracting rules. In this handbook, HMOs will be used to illustrate the benefits for both.

Many beneficiaries find that coordinated care plans are a good way to get more health care for their dollar. HMOs provide or arrange for all Medicare covered services, and generally charge you fixed monthly premiums and only small copayments. This means that if you join a coordinated care plan and get all of your services through the HMO, your out-of-pocket costs are usually more predictable. Also, depending on your health needs, those costs may be less than you would pay if you had to pay the regular Medicare deductible and coinsurance amounts.

Coordinated care plans may also offer benefits not covered by Medicare for little or no additional cost. Benefits may include preventive care, dental care, hearing aids and eyeglasses.

Who Can Enroll in Coordinated Care Plans?

Most Medicare beneficiaries are eligible to enroll in HMOs. HMOs cannot screen applicants to decide if they are healthy, or delay coverage for pre-existing conditions. The only enrollment criteria for Medicare HMOs are:

- You must be enrolled in Medicare Part B and continue to pay the Part B premiums (you do not need to be able to get Part A).
- You must live in the plan's service area.
- You cannot be receiving care in a Medicare-certified hospice.
- You cannot have permanent kidney failure.

If you develop permanent kidney failure after joining a coordinated care plan, the plan will provide, pay for, or arrange for your care. If you choose to receive hospice care after joining a coordinated care plan, the plan must inform you about hospice services available in your area. Staff at the coordinated care plan will explain how the hospice choice affects your plan membership.

Joining a Coordinated Care Plan

To join a coordinated care plan, contact plans in your area that have a contract with Medicare. All HMOs with Medicare contracts have an advertised open enrollment period at least once a year. Once you join, you may stay with the plan as long as it continues to contract with Medicare. And you may return to regular Medicare at any time. You can find out if there are HMOs in your area that contract with Medicare by calling the Health Care Financing Administration (HCFA) regional office nearest you. Medicare Coordinated Care contact numbers are listed in the box on page 7.

If you enroll in a coordinated care plan you will usually be required to get all care from the plan. In most cases, if you get services that are not authorized by the HMO (unless they are emergency services or services you urgently need when you are out of the plan's service area) **neither the plan nor Medicare will pay for the services.**

When you join an HMO, be sure to read your membership materials carefully to learn your rights and coverage.

Ending Enrollment in a Coordinated Care Plan

To end your enrollment in a coordinated care plan, send a signed request to your plan or to your local Social Security or Railroad Retirement Board office. You return to regular Medicare the first day of the month following the month your request is received by one of these offices. (If you leave a coordinated care plan to return to regular Medicare and buy a Medigap policy, you may have to wait for up to 6 months for the new Medigap policy to cover any pre-existing condition.)

If You Have Problems

If you belong to a Medicare HMO and you are unhappy with the quality of care, you can:

- Follow your HMO's grievance procedure, or
- Complain to your Peer Review Organization (PRO). PROs are groups of practicing doctors and other health care professionals under contract to Medicare to review the care provided to Medicare patients (see page 3).

If you have reason to believe that your Medicare HMO did not give you necessary care, inappropriately ended your enrollment, charged you an excessive premium, or falsified or misrepresented information, you can:

- Write to the Office of Prepaid Health Care Operations and Oversight, Room 4406 Cohen Building, 330 Independence Ave., SW, Washington, DC 20201.
- Describe your problem. The Office will see that your case is reviewed.

If you believe that your HMO has made an incorrect decision on coverage of benefits or payment of a claim, you can appeal—your appeal rights are similar to those provided under traditional Medicare. (See page 36 for more information about appeals.)

NOTE: A new Medicare supplement (Medigap) option is now available in some states. It is a kind of coordinated care plan called Medicare SELECT (see page 8 for more information).

If you need more information about Medicare and coordinated care plans, you can get a copy of *Medicare and Coordinated Care Plans* from the Consumer Information Center (see inside back cover).

Regional Office Coordinated Care Contacts

Health Care Financing Administration staff at the offices listed below can tell you if there are HMOs in your area that contract with Medicare.

Boston: (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont)
Beneficiary Services Branch (617) 565-1232

New York: (New Jersey, New York, Puerto Rico and theVirgin Islands)
Carrier Operations Branch (212) 264-8522

Philadelphia: (Delaware, District of Columbia, Maryland, Pennsylvania, Virginia and West Virginia)
Beneficiary Services Branch (215) 596-1332

Atlanta: (Alabama, North and South Carolina, Florida, Georgia, Kentucky, Mississippi, and Tennessee)
Beneficiary Services and HMO Branch (404) 331-2549

Chicago: (Illinois, Indiana, Michigan, Minnesota, Ohio and Wisconsin)
Beneficiary Services and HMO Branch (312) 353-7180

Dallas: (Arkansas, Louisiana, New Mexico, Oklahoma and Texas)
Beneficiary Services Branch (214) 767-6401

Kansas City: (Iowa, Kansas, Missouri and Nebraska)
Program Services Branch (816) 426-2866

Denver: (Colorado, Montana, North and South Dakota, Utah and Wyoming)
Beneficiary Services Branch (303) 844-4024 ext 238

San Francisco: (American Samoa, Arizona, California, Guam, Hawaii and Nevada)
Beneficiary Services Branch (415) 744-3617

Seattle: (Alaska, Idaho, Oregon and Washington)
Beneficiary Services Branch (206) 615-2354

Medicare and Other Insurance

Buying Health Insurance to Supplement Medicare

Medicare provides basic protection against the cost of health care, but it will not pay all of your medical expenses, nor most long-term care expenses. For this reason, many private insurance companies sell supplement (Medigap) insurance as well as separate long-term care insurance. The federal government does not sell or service such insurance.

Shopping for Medigap Insurance

If you are thinking about buying a new private insurance policy or replacing an old policy to supplement your Medicare protection or cover long-term care costs, you should shop carefully. You can get a booklet, *Guide to Health Insurance for People with Medicare*, to help you make Medicare supplement decisions. (See box below for more information about the guide.)

Open Enrollment Period for Medigap Policies

An open enrollment period for selecting Medigap policies guarantees that for **six months immediately following the effective date of Medicare Part B coverage**, people age 65 or older cannot be denied Medigap insurance or charged higher premiums because of health problems.

No matter how you enroll in Part B—whether by automatic notification or through an initial, special or general enrollment period—you are covered by the new guarantees if both of the following are true:

- You are 65 or older and are enrolled in Medicare based on age rather than disability.
- The date you get by adding six months to the effective date for your Part B coverage (printed on your Medicare card) is in the future. The date you get tells you when your Medigap open enrollment ends.

NOTE: Even when you buy your Medigap policy in this open enrollment period, the policy may still exclude coverage for "pre-existing conditions" during the first six months the policy is in effect. Pre-existing conditions are conditions that were either diagnosed or treated during the six-month period before the Medigap policy became effective.

New Standardized Medigap Policies

Most states have adopted regulations limiting the sale of Medigap insurance to no more than 10 standard policies. One of the 10 is a basic policy offering a "core package" of benefits. These standardized plans are identified by the letters A through J. Plan A is the core package. The other nine plans each have a different combination of benefits, but they all include the core package. The basic policy, offering the core package of benefits, is available in all states.

To find out what standardized policies are available in your state, check with your state insurance department. The telephone number of your state insurance department is probably listed under "state agencies" in your telephone book. If not, you can get a copy of the *Guide to Health Insurance for People with Medicare* (see box below).

In most cases, if you already have a Medigap policy, you may keep it but there are a few states where you must convert your policy to one of the standard plans. In all cases, if you buy a new policy, you will be required to choose a standardized plan.

Medicare SELECT

A new kind of Medigap insurance–available through 1994–has been introduced in 15 states. It is called Medicare SELECT. The difference between Medicare SELECT and regular Medigap insurance is that a Medicare SELECT policy may (except in emergencies) limit Medigap benefits to items and services provided by certain selected health care professionals or may pay only partial benefits when you get health care from other health care professionals .

You can order a free copy of the *Guide to Health Insurance for People With Medicare* from the Consumer Information Center. There is ordering information on the inside back cover of this book. The guide:

- Explains how supplemental insurance works.
- Tells how to shop for Medigap insurance.
- Gives information on the new standard plans.
- Gives information on Medicare SELECT.
- Lists names, addresses and telephone numbers of state insurance departments and state agencies on aging. Some of these offices may have free counseling services available.

Insurers, including some HMOs, offer Medicare SELECT in the same way standard Medigap insurance is offered. The policies are required to meet certain federal standards and are regulated by the states in which they are approved. The premiums charged for Medicare SELECT policies are expected to be lower than premiums for comparable Medigap policies that do not have this selected-provider feature.

Medicare SELECT policies are permitted to be offered in Alabama, Arizona, California, Florida, Illinois, Indiana, Kentucky, Massachusetts, Minnesota, Missouri, North Dakota, Ohio, Texas, Washington and Wisconsin. If you live in one of these states, you can ask your state insurance department about the Medicare SELECT policies that have been approved for sale in the state.

Employment-related Retiree Coverage Instead of Medigap

Some retired people can get health coverage through their former employer or union. This health coverage may supplement Medicare but it is not Medigap insurance and does not have to meet federal and state Medigap requirements. (See below for rules about selling Medigap Insurance.)

Retiree coverage is usually provided free or at a greatly reduced price and may be a good bargain. But the benefits may not be adequate to serve as your supplement to Medicare. Does your retiree plan have an "escape clause," so that benefits might be changed? On the other hand, does your retiree plan protect you from the preexisting condition restriction that might be applied during the first six months under a Medigap policy? Check carefully before you decide whether to stay with your retiree coverage or buy a Medigap policy.

Medicaid Recipients

Low-income people who are eligible for Medicaid usually do not need additional insurance. Medicaid pays for certain health care benefits beyond those covered by Medicare, such as long-term nursing home care. If you have Medigap insurance purchased on or after November 5, 1991, and you become eligible for Medicaid, you can ask that the Medigap benefits and premiums be suspended for up to two years while you are covered by Medicaid. If you become ineligible for Medicaid benefits during the two years, your Medigap policy is automatically reinstituted if you give proper notice and begin paying premiums again.

Coordinated Care Plans Instead of Medigap

Coordinated care plans that contract with Medicare are not Medigap plans, but they can be an alternative to standard Medigap insurance. (See page 6 for more information about coordinated care plans.)

There are Rules for Selling Medigap Insurance

Both state and federal laws govern sales of Medigap insurance. Companies or agents selling Medigap insurance must avoid certain illegal practices. Federal criminal and civil penalties (fines) may be imposed against any insurance company or agent that knowingly:

- Sells you a health insurance policy that duplicates your Medicare or Medicaid coverage, or any private health insurance coverage you may have.
- Tells you that they are employees or agents of the Medicare program or of any government agency.
- Makes a false statement that a policy meets legal standards for certification when it does not.
- Sells you a Medigap policy that is not one of the 10 approved standard policies (after the new standards have been put in place in your state).
- Denies you your Medigap open enrollment period by refusing to issue you a policy, placing conditions on the policy, or discriminating in the price of a policy because of your health status, claims experience, receipt of health care, or your medical condition.
- Uses the U.S. mail in a state for advertising or delivering health insurance policies to supplement Medicare if the policies have not been approved for sale in that state.

If You Suspect Illegal Sales Practices

If you suspect that you have been the victim of illegal sales practices, you should report these practices to your state insurance department. States are responsible for the regulation of insurance policies issued within their boundaries. Because federal laws also govern Medigap sales practices, you should also report the practices to the appropriate federal officials.

Your state insurance department may be listed in your telephone book. If not, you can get a copy of the booklet, *Guide to Health Insurance for People with Medicare* (see box on page 8).

To talk to federal officials about the suspected illegal sales practices, you may call this number : 1-800-638-6833.

When Other Insurance Pays Before Medicare

If any of the following insurance situations applies to you, please notify your doctor, hospital, and all other providers of services. For more information about any of these insurance situations, ask Social Security for a copy of *Medicare and Other Health Benefits*. The publication is also available free from the Consumer Information Center (see inside back cover).

When You or Your Spouse Continue To Work

Medicare has special rules that apply to beneficiaries who have employer group health plan coverage through their current employment or the current employment of a spouse.

Group health plans of employers with 20 or more employees are primary payers and Medicare is secondary payer for workers age 65 or older, and workers' spouses age 65 or older. Group health plans must offer these people the same health insurance benefits under the same conditions offered to younger workers and spouses. You and your spouse have the option to reject the plan offered by the employer. If you reject the employer's health plan, Medicare will remain the primary health insurance payer. In that case, the employer's plan is not permitted to offer you coverage that supplements Medicare covered services. If your employer plan denies you coverage, offers you different coverage, or pays benefits that are secondary to Medicare, notify the carrier that handles your Medicare claims.

If You Are Disabled and Under Age 65

Medicare is the secondary payer for certain disabled people who have premium-free Medicare Part A and are covered under their employer's health plan or the employer health plan of an employed family member. This secondary payer provision applies to group health plans of employers that employ 100 or more people. The secondary payer provision also applies to group health plans of employers with fewer than 100 employees if their employers are part of a multi-employer plan in which at least one employer has 100 or more employees.

Other Situations Where Medicare is the Secondary Payer

If you have a work-related illness or injury, services provided as treatment of that illness or injury should be covered by workers' compensation or federal black lung benefits. It is important that your Medicare claim form note that the treatment is related to a work-related illness or injury, even if the injury or illness occurred in the past.

Medicare is a secondary payer during a period (generally 18 months) for beneficiaries who have Medicare solely on the basis of permanent kidney failure, if they have employer group health plan coverage themselves or through a family member.

Medicare also serves as the secondary payer in cases where no-fault insurance or liability insurance is available as the primary payer.

Although Medicare benefits are secondary to benefits paid by liability insurers, Medicare may make a **conditional** payment if it receives a claim for services covered by liability insurance. In those cases, Medicare may pay the claim: then, when a liability settlement is reached, Medicare recovers its conditional payment from the settlement amount.

If You Have or Can Get Both Medicare and Veterans Benefits

If you have or can get both Medicare and veterans benefits, you may choose to get treatment under either program. But, Medicare:

- Cannot pay for services you receive from Veterans Affairs (VA) hospitals or other VA facilities, except for certain emergency hospital services; and
- Generally cannot pay if the VA pays for VA-authorized services that you get in a non-VA hospital or from a non-VA physician.

Since July 1986, the VA has been charging coinsurance payments to some veterans who have non-service connected conditions for treatment in a VA hospital or medical facility, or for VA-authorized treatment by non-VA sources. The VA charges coinsurance payments when the veteran's income exceeds a particular level. If the VA charges you a coinsurance payment for **VA-authorized care by a non-VA physician or hospital**, Medicare may be able to reimburse you, in whole or in part, for your VA coinsurance payment obligation. (If you have Medigap insurance, your Medigap policy may pay the VA coinsurance and deductible obligations, even if Medicare cannot.)

NOTE: Medicare cannot reimburse you for VA coinsurance payments for services furnished by VA hospitals and facilities, unless the services are emergency inpatient or outpatient **hospital** services. Then, the

Medicare payment is subject to Medicare deductible and coinsurance amounts.

If you have questions about whether the VA or Medicare should pay for your doctor or other services covered under Medicare Part B, contact your Medicare carrier. If you have questions about whether the VA or Medicare should pay for hospital or other services covered under Medicare Part A, ask the provider of services to check with the Medicare intermediary.

The Data Match

In 1989, Congress passed a law that will help Medicare get back an estimated $1 billion in taxpayer money. The law enables Medicare to get accurate information about beneficiaries' health insurance.

The law authorizes the Health Care Financing Administration (the agency that administers the Medicare program), the Internal Revenue Service, and the Social Security Administration to share information about whether Medicare beneficiaries or their spouses are working and whether they have employment-related health insurance.

The process for sharing information from other agencies is called the Data Match. The Data Match will help Medicare find cases where another insurer should have paid first on Medicare beneficiaries' health care claims. A designated Medicare contractor will contact employers to confirm health insurance coverage information. (For information about your rights under the Data Match, see "Your Rights Under the Privacy Act," page 5.)

What Medicare Does Not Pay For

Custodial Care

Medicare does not pay for custodial care when that is the **only** kind of care you need. Care is considered custodial when it is primarily for the purpose of helping you with daily living or meeting personal needs and could be provided safely and reasonably by people without professional skills or training. Much of the care provided in nursing homes to people with chronic, long-term illnesses or disabilities is considered custodial care. For example, custodial care includes help in walking, getting in and out of bed, bathing, dressing, eating, and taking medicine. Even if you are in a participating hospital or skilled nursing facility, Medicare does not cover your stay if you need only custodial care.

Care Not Reasonable and Necessary Under Medicare Program Standards

Medicare does not pay for services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury. These services include drugs or devices that have not been approved by the Food and Drug Administration (FDA); medical procedures and services performed using drugs or devices not approved by FDA;* and services, including drugs or devices, not considered safe and effective because they are experimental or investigational.

If a doctor admits you to a hospital or skilled nursing facility when the kind of care you need could be provided elsewhere (for example, at home or in an outpatient facility), your stay will not be considered reasonable and necessary, and Medicare will not pay for your stay. If you stay in a hospital or skilled nursing facility longer than you need to be there, Medicare payments will end when inpatient care is no longer reasonable and necessary.

If a doctor (or other practitioner) comes to treat you—or you visit him or her for treatment—more often than is medically necessary, Medicare will not pay for the "extra" visits. Medicare will not pay for more services than are reasonable and necessary for your treatment.

Medicare always bases decisions about what is reasonable and necessary on professional medical advice.

Services Medicare Does Not Pay For

Medicare, by law, cannot pay for certain services. These include services performed by immediate relatives or members of your household, and services paid for by another government program. If you have a question about whether Medicare pays for a particular service, ask your Medicare carrier. (See pages 39 to 44 for the name and telephone number of your carrier.)

Limitation of Liability

Under Medicare law you will not be held responsible for payment of the cost of certain health care services for which you were denied Medicare payment if you did not know or you could not reasonably be expected to know (for example, you had not received a written notice) that the services were not covered by Medicare. This provision is called limitation of liability and is often referred to as a "waiver of liability." This protection from financial liability applies only when the care was denied because it was one of the following:

- Custodial care.
- Not "reasonable and necessary" under Medicare program standards for diagnosis or treatment.
- For home health services, the patient was not homebound or not receiving skilled nursing care on an intermittent basis.
- The only reason for the denial is that, in error, you were placed in a skilled nursing facility bed that was not approved by Medicare.

This limitation of liability provision does not apply to Medicare Part B services provided by a non-participating physician or supplier who did not accept assignment of the claim. However, in certain situations Medicare law will protect you from paying for services provided by a non-participating physician on a non-assigned basis that are denied as "not reasonable and necessary." If your physician knows or should know that Medicare will not pay for a particular service as "not reasonable and necessary," he or she must give you written notice—before performing the service—of the reasons why he or she believes Medicare will not pay. The physician must get your written agreement to pay for the services. If you did

*Some services are not covered by Medicare even when FDA has approved the drug or device used.

not receive this notice, you are not required to pay for the service. If you did pay, you may be entitled to a refund. (This written notice is not an official Medicare determination. If you disagree with it, you may ask your doctor to submit a claim for payment to get an official Medicare determination.)

Medicare Hospital Insurance (Part A)

What Medicare Part A Includes

Medicare Part A helps pay for four kinds of medically necessary care:

1) Inpatient hospital care.
2) Inpatient care in a skilled nursing facility following a hospital stay.
3) Home health care.
4) Hospice care.

There is a limit on how many days of hospital or skilled nursing facility care Medicare helps pay for in each benefit period. But, your Part A protection is renewed every time you start a new benefit period. (Benefit periods are described below.)

Skilled nursing facility care is the only type of nursing home care that Medicare covers. **Medicare does not pay for care that is primarily custodial.** (See pages 17 and 20 for more about custodial care.)

Benefit Periods

A benefit period is a way of measuring your use of services under Medicare Part A. Your first benefit period starts the first time you receive inpatient hospital care after your Hospital Insurance begins. A benefit period ends when you have been out of a hospital or other facility primarily providing skilled nursing or rehabilitation services for 60 days in a row (including the day of discharge). If you remain in a facility (other than a hospital) that primarily provides skilled nursing or rehabilitation services, a benefit period ends when you have not received any skilled care there for 60 days in a row. After one benefit period has ended, another one will start whenever you again receive inpatient hospital care.

There is no limit to the number of benefit periods you can have for hospital and skilled nursing facility care. However, special limited benefit periods apply to hospice care (see page 19).

Here are two examples of how the benefit period works:

Example 1: Ms. Jones enters the hospital on January 5. She is discharged on January 15. She has used 10 days of her first benefit period. Ms. Jones is not hospitalized again until July 20. Since more than 60 days elapsed between her hospital stays, she begins a new benefit period, her Part A coverage is completely renewed, and she will again pay the hospital deductible. (The hospital deductible is explained on page 15.)

Example 2: Ms. Smith enters the hospital on August 14. She is discharged on August 24. She also has used 10 days of her first benefit period. However, she is then readmitted to the hospital on September 20. Since fewer than 60 days elapsed between hospital stays, Ms. Smith is still in her first benefit period and will not be required to pay another hospital deductible. This means that the first day of her second admission is counted as the eleventh day of hospital care in that benefit period. Ms. Smith will not begin a new benefit period until she has been out of the hospital (and has not received any skilled care in a skilled nursing facility) for 60 consecutive days.

How Medicare Pays for Part A Services

Medicare Part A helps pay for most but not all of the services you receive in a hospital or skilled nursing facility or from a home health agency or hospice program. There are covered services and noncovered services under each kind of care. Covered services are services and supplies that Part A pays for.

Hospitals, skilled nursing facilities, home health agencies and hospices are called "providers" under the Medicare Part A program. Providers submit their claims directly to Medicare—you cannot submit claims for their services. The provider will charge you for any part of the Part A deductible you have not met and any coinsurance payment you owe. Providers cannot require you to make a deposit before being admitted for inpatient care that is or may be covered under Part A of Medicare.

When a hospital, skilled nursing facility, home health agency, or hospice sends Medicare a Part A claim for payment, you get a Notice of Utilization that explains the decision Medicare made on the claim. **This notice is not a bill.** If you have any questions about the notice, get in touch with the people who sent you the notice.

When You Are a Hospital Inpatient

Medicare Part A helps pay for inpatient hospital care if **all** of the following four conditions are met:

1) A doctor prescribes inpatient hospital care for treatment of your illness or injury.

2) You require the kind of care that can be provided only in a hospital.
3) The hospital is participating in Medicare.*
4) The Utilization Review Committee of the hospital, a Peer Review Organization or an intermediary does not disapprove your stay.

If you meet these four conditions, Medicare will help pay for up to 90 days of medically necessary inpatient hospital care in each benefit period.**

During 1993, from the first day through the 60th day in a hospital during each benefit period, Part A pays for all covered services except the **first** $676. This is called the inpatient hospital deductible. (A deductible is an amount you owe before Medicare begins paying for services and supplies covered by the program.) **The hospital may charge you the deductible only for your first admission in each benefit period**. If you are discharged and then readmitted before the benefit period ends, you do not have to pay the deductible again.

From the 61st through the 90th day in a hospital during each benefit period, Part A pays for all covered services **except for $169 a day**. This daily amount is called coinsurance. The hospital charges you the $169.

Hospital reserve days (explained below) can help with your expenses if you need more than 90 days of inpatient hospital care in a benefit period.

Medicare Part A does not pay for the services of doctors and certain other practitioners, even though you receive these services in a hospital. Instead, those services are covered under Medicare Part B. (A description of Medicare Part B begins on page 21.)

Major services covered under Part A when you are a hospital inpatient:

- A semiprivate room (two to four beds in a room).
- All your meals, including special diets.
- Regular nursing services.
- Costs of special care units, such as intensive care or coronary care units.
- Drugs furnished by the hospital during your stay.
- Blood transfusions furnished by the hospital during your stay. (See page 16 for information about coverage of blood.)
- Lab tests included in your hospital bill.
- X-rays and other radiology services, including radiation therapy, billed by the hospital.
- Medical supplies such as casts, surgical dressings, and splints.
- Use of appliances, such as a wheelchair.
- Operating and recovery room costs.
- Rehabilitation services, such as physical therapy, occupational therapy, and speech pathology services.

Some services not covered under Part A when you are a hospital inpatient:

- Personal convenience items that you request such as a telephone or television in your room.
- Private duty nurses.
- Any extra charges for a private room unless it is determined to be medically necessary.

NOTE: If you disagree with a decision on the amount Medicare will pay on a claim or whether services you receive are covered by Medicare, you always have the right to appeal the decision (see page 35).

Hospital Inpatient Reserve Days

Medicare helps pay for your care in a hospital for up to 90 days in each benefit period. Medicare Part A also includes an extra 60 hospital days you can use if you have a long illness and have to stay in the hospital for more than 90 days. These extra days are called reserve days.

You have only 60 reserve days in your lifetime. For example, if you use 8 reserve days in your first hospital stay this year, the next time you visit a hospital you will have only 52 reserve days left to use, whether or not you have a new benefit period.

You can decide when you want to use your reserve days. After you have been in the hospital 90 days, you can use all or some of your 60 reserve days if you wish.

If you do not want to use your reserve days, you must tell the hospital in writing, either when you are admitted to the hospital, or at any time afterwards up to 90 days after you are discharged. If you use reserve days and then decide that you did not want to use them, you must request approval from the hospital to get them restored.

During 1993, Medicare Part A pays for all covered services **except $338 a day** for each reserve day you use. You are responsible for paying this $338.

*Under certain conditions, Medicare helps pay for emergency inpatient care you receive in a non-participating hospital.

**Medicare pays for only limited inpatient care in a psychiatric hospital (see page16). The hospital can tell you about these limits.

All Medigap plans pay some part of hospital bills after you have used all your reserve days. (See page 8 for more information about Medigap insurance.)

Coverage of Blood Under Part A

Part A helps pay for blood (whole blood or units of packed red blood cells), blood components, and the cost of blood processing and administration. If you receive blood as an inpatient of a hospital or skilled nursing facility, Part A will pay for these blood costs, except for any nonreplacement fees charged for the first three pints of whole blood or units of packed red cells per calendar year. (The nonreplacement fee is the amount that some hospitals and skilled nursing facilities charge for blood that is not replaced.)

You are responsible for the nonreplacement fees for the first three pints or units of blood furnished by a hospital or skilled nursing facility. If you are charged nonreplacement fees, you have the option of either paying the fees or having the blood replaced. If you choose to have the blood replaced, you can either replace the blood personally or arrange to have another person or an organization replace it for you. A hospital or skilled nursing facility cannot charge you for any of the first three pints of blood you replace or arrange to replace. (If you have already paid for or replaced blood under Medicare **Part B** during the calendar year, you do not have to meet those costs again under Medicare **Part A**. See page 21 for an explanation of coverage of blood under Medicare Part B.)

Care in a Psychiatric Hospital

Part A helps pay for no more than 190 days of inpatient care in a participating psychiatric hospital in your lifetime. Once you have used these 190 days, Part A does not pay for any more inpatient care in a psychiatric hospital.

Also, a special rule applies if you are in a participating psychiatric hospital at the time your Part A starts. Social Security can give you more information.

Care Outside the United States

Medicare generally does not pay for hospital or medical services outside the United States. (Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands are considered part of the United States.)

If you are planning to travel outside the United States, you may want to buy special short-term health insurance for foreign travel. If you have other health insurance in addition to Medicare, check to see if health care in a foreign country is covered under your policy.

There are rare emergency cases where Medicare can pay for care in Canada or Mexico. Also, Medicare can sometimes pay if a Mexican or Canadian hospital is closer to your home than the nearest U.S. hospital that can provide the care you need. If you get emergency treatment in a Canadian or Mexican hospital or if you live near a Canadian or Mexican hospital, ask someone who works at the hospital about Medicare coverage, or have the hospital help you contact the Medicare intermediary.

Care in a Christian Science Sanatorium

Medicare Part A helps pay for inpatient hospital and skilled nursing facility services you receive in a participating Christian Science sanatorium if it is operated or listed and certified by the First Church of Christ, Scientist, in Boston. (However, Medicare Part B will not pay for the practitioner.)

The Prospective Payment System

Medicare pays for most inpatient hospital care under the Prospective Payment System (PPS). Under PPS, hospitals are paid a predetermined rate per discharge for inpatient services furnished to Medicare beneficiaries. The predetermined rates are based on payment categories called Diagnosis Related Groups, or DRGs. In some cases, the Medicare payment will be more than the hospital's costs; in other cases, the payment will be less than the hospital's costs. In special cases, where costs for necessary care are unusually high or the length of stay is unusually long, the hospital receives additional payment. **But even if Medicare pays the hospital less than the cost of your care, you do not have to make up the difference.**

It is important to remember that the PPS system does not change your Medicare Part A protection as described in this handbook. PPS does not determine the length of your stay in the hospital or the extent of care you receive. The law requires participating hospitals to accept Medicare payments as payment in full, and those hospitals are prohibited from billing the Medicare patient for anything other than the applicable deductible and coinsurance amounts, plus any amounts due for noncovered items or services such as television, telephone or private duty nurses.

Skilled Nursing Facility Care

Medicare Part A can help pay for certain inpatient care in a Medicare-participating skilled nursing facility following a hospital stay. Your condition must require daily skilled nursing or skilled rehabilitation services which, as a practical matter, can only be provided in a skilled nursing facility, and the skilled care you receive must be based on a doctor's orders.

What is a Skilled Nursing Facility?

A skilled nursing facility is a specially qualified facility that specializes in skilled care. It has the staff and equipment to provide skilled nursing care or skilled rehabilitation services and other related health services. Skilled nursing care means care that can only be performed by, or under the supervision of, licensed nursing personnel. Skilled rehabilitation services may include such services as physical therapy performed by, or under the supervision of, a professional therapist.

Most nursing homes in the United States are **not** skilled nursing facilities that participate in Medicare. In some facilities, only certain portions participate in Medicare. If you are not sure whether a facility participates in Medicare as a skilled nursing facility, ask someone in the facility's business office. If staff at the facility cannot tell you, ask Social Security to check with the Health Care Financing Administration.

When Can Medicare Pay?

Medicare Part A can help pay for your care in a Medicare-participating skilled nursing facility if you meet **all of these five conditions**:

1) Your condition requires daily skilled nursing or skilled rehabilitation services which, as a practical matter, can only be provided in a skilled nursing facility.
2) You have been in a hospital at least three days in a row (not counting the day of discharge) before you are admitted to a participating skilled nursing facility.
3) You are admitted to the facility within a short time (generally within 30 days) after you leave the hospital.
4) Your care in the skilled nursing facility is for a condition that was treated in the hospital, or for a condition that arose while you were receiving care in the skilled nursing facility for a condition which was treated in the hospital.
5) A medical professional certifies that you need, and you receive, skilled nursing or skilled rehabilitation services on a daily basis.

All five conditions must be met. Remember, you must need skilled nursing care or skilled rehabilitation services on a daily basis. Part A will not pay for your stay if you need skilled nursing or rehabilitation services only occasionally, such as once or twice a week, or if you do not need to be in a skilled nursing facility to get skilled services. Also, Medicare will not pay for your stay if you are in a skilled nursing facility mainly because you need custodial care.

Skilled Care or Custodial Care?

The only type of "nursing home" care Medicare helps pay for is skilled nursing facility care. Medicare does not pay for custodial care when that is the only kind of care you need.

Care is considered custodial when it is primarily for the purpose of helping the patient with daily living or meeting personal needs, and could be provided safely and reasonably by people without professional skills or training. For example, custodial care includes help in walking, getting in and out of bed, bathing, dressing, eating and taking medicine.

When your stay in a skilled nursing facility is covered by Medicare, Part A helps pay for a maximum of 100 days in each benefit period, but only if you need daily skilled nursing care or rehabilitation services for that long.

If you leave a skilled nursing facility and are readmitted within 30 days, you do not have to have a new three day stay in the hospital for your care to be covered. If you have some of your 100 days left and you need skilled nursing or rehabilitation services on a daily basis for further treatment of a condition treated during your previous stay in the facility, Medicare will help pay.

In each benefit period, Part A pays for all covered services for the first 20 days you are in a skilled nursing facility. During 1993, for days 21 through 100, Part A pays for all covered services except for $84.50 a day. You may be charged up to this daily coinsurance amount by the skilled nursing facility.

Medicare Part A does not cover your doctor's services while you are in a skilled nursing facility. Medicare

Part B covers doctors' services. (A description of Medicare Part B begins on page 21.)

Major services covered under Part A when you are in a skilled nursing facility:

- A semiprivate room (two to four beds in a room).
- All your meals, including special diets furnished by the facility.
- Regular nursing services.
- Physical, occupational, and speech therapy.
- Drugs furnished by the facility during your stay.
- Blood transfusions furnished during your stay. (See page 16 for information about coverage of blood.)
- Medical supplies such as splints and casts furnished by the facility.
- Use of appliances such as a wheelchair furnished by the facility.

Some services not covered under Part A when you are in a skilled nursing facility:

- Personal convenience items that you request such as a television in your room.
- Private duty nurses.
- Any extra charges for a private room, unless it is determined to be medically necessary.

Rules That Protect You

Skilled nursing facilities cannot require you to pay a deposit or other payment as a condition of admission to the facility unless it is clear that services are not covered by Medicare.

If you are already an inpatient in a skilled nursing facility and the staff at the facility decides you no longer need the level of skilled care covered by Medicare, they must notify you immediately. If you disagree with this decision, the facility must submit your claim at your request to Medicare for an official Medicare decision on coverage. The facility may not require you to pay a deposit until Medicare issues its decision. You must pay for any coinsurance while your claim is being processed, and for any services which are never covered by Medicare.

Complaints and Appeals

If you want to complain about a skilled nursing facility's treatment of patients or other conditions that concern you, you can contact the state survey agency. Each skilled nursing facility can give you the telephone number and address of the state survey agency if you ask for it. You can also look at a copy of the skilled nursing facility's latest certification survey report. The survey report will tell you the results of the state survey agency's review of how well the agency thinks the facility followed the rules about patient's rights, safety and quality of care.

Also, if you disagree with a decision on the amount Medicare will pay on a claim or whether services you receive are covered by Medicare, you always have the right to appeal the decision (see page 35).

Home Health Care

If you need skilled health care in your home for the treatment of an illness or injury, Medicare pays for covered home health services furnished by a participating home health agency. A home health agency is a public or private agency that specializes in giving skilled nursing services and other therapeutic services, such as physical therapy, in your home. (A hospital or other facility that mainly provides skilled nursing or rehabilitation services cannot be considered your home.)

Medicare pays for home health visits only if **all four** of the following conditions are met:

1) The care you need includes intermittent skilled nursing care, physical therapy, or speech therapy.
2) You are confined to your home (homebound).
3) You are under the care of a physician who determines you need home health care and sets up a home health plan for you.
4) The home health agency providing services participates in Medicare.

Once all four of these conditions are met, either Medicare Part A or Medicare Part B will pay for all medically necessary home health services. When you no longer need intermittent skilled nursing care, physical therapy, or speech therapy, Medicare will pay for home health services if you continue to need occupational therapy.

Medicare home health services do not include coverage for general household services such as laundry, meal preparation, shopping, or other home care services furnished mainly to assist people in meeting personal, family, or domestic needs.

To determine whether you can get services under the Medicare home health benefit, ask your physician to refer you to a Medicare participating home health agency. The home health agency will evaluate your case and tell

you whether you meet the requirements for Medicare coverage. Home health agencies should not charge for this evaluation.

Home health services covered by Medicare:

- Part-time or intermittent skilled nursing care. (This can include eight hours of reasonable and necessary care per day for up to 21 consecutive days—or longer in certain circumstances.)
- Physical therapy.
- Speech therapy.

If you need intermittent skilled nursing care, or physical or speech therapy, Medicare also pays for:

- Occupational therapy.
- Part-time or intermittent services of home health aides.
- Medical social services.
- Medical supplies.
- Durable medical equipment (80 percent of approved amount).

Home health services not covered by Medicare:

- 24-hour-a-day nursing care at home.
- Drugs and biologicals.
- Meals delivered to your home.
- Homemaker services.
- Blood transfusions.

Medicare pays the full approved cost of all covered home health visits. You may be charged only for any services or costs that Medicare does not cover. However, if you need durable medical equipment, you are responsible for a 20 percent coinsurance payment for the equipment. (See page 26 for more information about durable medical equipment.)

The home health agency will submit the claim for payment. You do not have to send in any bills yourself.

NOTE: If you disagree with a decision on the amount Medicare will pay on a claim or whether services you receive are covered by Medicare, you always have the right to appeal the decision (see page 35).

Hospice Care

A hospice is a public agency or private organization that is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people.

Hospice care is a special type of care for people who are terminally ill. It includes both home care and inpatient care, when needed, and a variety of services not otherwise covered under Medicare. Under the Medicare hospice benefit, Medicare pays for services every day and also permits a hospice to provide appropriate custodial care, including homemaker services and counseling.

Medicare Part A helps pay for hospice care if **all three** of these conditions are met:

1) A doctor certifies that the patient is terminally ill.
2) The patient chooses to receive care from a hospice instead of standard Medicare benefits for the terminal illness.
3) Care is provided by a Medicare-participating hospice program.

Special benefit periods apply to hospice care. Part A pays for two 90-day periods, followed by a 30-day period, and—when necessary—an extension period of indefinite duration. If a beneficiary cancels hospice care during one of the first three benefit periods, any days left in that period are lost, but the remaining benefit period(s) are still available. And, a beneficiary may disenroll from the hospice during any benefit period, return to regular Medicare coverage, then later re-elect the hospice benefit if another benefit period is available.

Two Benefit Period Examples:

- Mr. Jones cancelled his hospice care at the end of 59 days during his first 90-day benefit period. He lost the 31 remaining days of the first 90-day period. But if he wants to, he can choose hospice care again. He still has a 90-day period, a 30-day period, and the indefinite extension period.
- Ms. Smith cancelled hospice care during her final extension period. She cannot use the Medicare hospice benefit again.

There are no deductibles under the hospice benefit. The beneficiary does not pay for Medicare-covered services for the terminal illness, except for small coinsurance amounts for outpatient drugs and inpatient respite care.

The patient is responsible for five percent of the cost of outpatient drugs or $5 toward each prescription, whichever is less. For inpatient respite care, the patient pays five percent of the Medicare-allowed rate (approximately $4.48 per day in 1993). The rate varies slightly depending on the area of the country.

Respite care under the hospice program is a short-term inpatient stay in a facility. The Medicare beneficiary's inpatient stay gives temporary relief—a respite—to the person who regularly assists with home

care. Each inpatient respite care stay is limited to no more than five days in a row.

While receiving hospice care, if a patient requires treatment for a condition not related to the terminal illness, Medicare continues to help pay for all necessary covered services under the standard Medicare benefit program.

Services covered by Part A when provided by a hospice:

- Nursing services.
- Doctors' services.
- Drugs, including outpatient drugs for pain relief and symptom management.
- Physical therapy, occupational therapy and speech-language pathology.
- Home health aide and homemaker services.
- Medical social services.
- Medical supplies and appliances.
- Short-term inpatient care, including respite care.
- Counseling.

The Medicare Part A hospice benefit **does not** pay for treatments other than for pain relief and symptom management of a terminal illness. Regular Medicare can usually help pay for treatments not related to the terminal illness.

NOTE: If you disagree with a decision on the amount Medicare will pay on a claim or whether services you receive are covered by Medicare, you always have the right to appeal the decision (see page 35).

Medicare Medical Insurance (Part B)

What Medicare Part B Includes

Medicare Part B helps pay for:

- Doctors' services.
- Outpatient hospital care.
- Diagnostic tests.
- Durable medical equipment.
- Ambulance services.
- Many other health services and supplies that are not covered by Medicare Part A.

The following sections tell you more about these different kinds of care, the services that are and are not covered by Medicare Part B, and what part of your medical expenses Medicare will pay.

Deductible and Coinsurance Amounts Under Part B

The Annual Deductible

You must pay the first $100 in approved charges for covered medical expenses in 1993. This is called the Medicare Part B annual deductible. You need to meet this $100 deductible only once during the year, and the deductible can be met by any combination of covered expenses. You do not have to meet a separate deductible for each different kind of covered service you receive.

The Blood Deductible

You must pay any nonreplacement fees charged for the first three pints or units of blood and blood components you use each year. (The nonreplacement fee is the amount that some practitioners and facilities charge for blood that is not replaced.) This is called the Medicare Part B blood deductible. After you have replaced or paid for the first three pints of blood **and** you have met the $100 annual deductible, Medicare will pay 80 percent of the approved amount for blood, starting with the fourth pint. (If you have already paid for or replaced some units of blood under Medicare **Part A** during the calendar year, you do not have to pay for or replace that number of units again under Medicare **Part B**.)

Coinsurance

After you pay the annual deductible, you will owe a share of the Medicare-approved amount for most services and supplies. This share is called coinsurance. Usually, your coinsurance share is 20 percent of the Medicare-approved amount.

Medicare determines the approved amount for each service you receive. If your services were provided "**on assignment**," you pay only the coinsurance (see page 28 for an explanation of assignment).

If your services were **not provided "on assignment,"** and the charges for your services were more than the Medicare-approved amount, you usually owe the Medicare coinsurance plus certain charges above the Medicare-approved amount. (See "Medicare Approved Amounts" on page 29.) There are limits on the amount your doctor can charge you.

NOTE: This explanation of your deductible and coinsurance amounts describes Medicare's payment system for most services covered by Medicare Part B. In cases where payment for services is handled in a different way, you will be given an explanation along with the description of services covered. (You will find more information about how Medicare pays Part B claims in the section beginning on page 28.)

Doctors' Services Covered By Medicare Part B

Medicare Part B helps pay for covered services you receive from your doctor in his or her office, in a hospital, in a skilled nursing facility, in your home, or any other location.

Major doctors' services covered by Medicare Part B:

- Medical and surgical services, including anesthesia.
- Diagnostic tests and procedures that are part of your treatment.
- Radiology and pathology services by doctors while you are a hospital inpatient or outpatient.
- Treatment of mental illness. (Medicare payments for treatment are limited; see page 27)
- Other services such as:
  - —X-rays.
  - —Services of your doctor's office nurse.
  - —Drugs and biologicals that cannot be self-administered.
  - —Transfusions of blood and blood components.
  - —Medical supplies.
  - —Physical/occupational therapy and speech pathology services.

Some doctors' services not covered by Medicare Part B:

- Routine physical examinations, and tests directly related to such examinations (except some Pap smears and mammograms, see page25).
- Most routine foot care and dental care.
- Examinations for prescribing or fitting eyeglasses or hearing aids.
- Most immunizations (See Drugs and Biologicals, page 26).
- Cosmetic surgery, unless it is needed because of accidental injury or to improve the function of a malformed part of the body.

Types of Doctors

Most doctors' services are furnished by a doctor of medicine or a doctor of osteopathy . Other "physicians" that can furnish some covered services include chiropractors, doctors of podiatric medicine (podiatrists), doctors of dental surgery or of dental medicine (dentists), and doctors of optometry (optometrists).

Chiropractors' Services

Medicare helps pay for only one kind of treatment furnished by a licensed chiropractor: manual manipulation of the spine to correct a subluxation that is demonstrated by X-ray. Your Medicare carrier decides, based on practise patterns in your community and your medical condition, how many visits are medically necessary to treat your subluxation. Medicare Part B does not pay for any other diagnostic or therapeutic services, including X-rays, furnished by a chiropractor.

Podiatrists' Services

Medicare Part B helps pay for any covered services of a licensed podiatrist to treat injuries and diseases of the foot. Examples of common problems include ingrown toenails, hammer toe deformities, bunion deformities and heel spurs.

Medicare generally does not pay for routine foot care such as cutting or removal of corns and calluses, trimming of nails, and other hygienic care. But, Medicare does help pay for some routine foot care if you are being treated by a medical doctor for a medical condition affecting your legs or feet (such as diabetes or peripheral vascular disease) which requires that the routine care be performed by a podiatrist or by a doctor of medicine or osteopathy.

Dentists' Services

Medicare Part B generally does **not** pay for care in connection with the treatment, filling, removal, or replacement of teeth; root canal therapy; surgery for impacted teeth; or other surgical procedures involving the teeth or structures directly supporting the teeth. However, Medicare **does** help pay for services of a dentist in certain cases when the medical problem is more extensive than the teeth or structures directly supporting them. (If you need to be hospitalized because of the severity of a dental procedure, Medicare Part A may pay for your **inpatient** hospital stay even if the dental care itself is not covered by Medicare. Ask your dentist whether your hospital stay would be considered an inpatient stay.)

Optometrists' Services

Medicare helps pay for Medicare-covered vision care, including the services of an optometrist if the optometrist is legally authorized to perform those services by the state in which he or she performs them. However, Medicare will not pay for routine eye exams and usually will not pay for eyeglasses. (Medicare will pay for cataract spectacles, cataract contact lenses, or intraocular lenses that replace the natural lens of the eye after cataract surgery. Medicare will also pay for one pair of conventional eyeglasses or conventional contact lenses if necessary after cataract surgery with insertion of an intraocular lens.)

Second Opinion Before Surgery

Sometimes your doctor may recommend surgery for the treatment of a medical problem. In some cases, surgery is unavoidable. But there is increasing evidence that many conditions can be treated equally well without surgery. Because even minor surgery involves some risk, we recommend that you get an opinion from a second doctor to help you decide about surgery. Medicare will help pay for a second opinion. Medicare will also help pay for a third opinion if the first and second opinions contradict each other.

Your own doctor is the best source for referral to another doctor. But, if you wish, you can call your Medicare Part B carrier for the names and phone numbers of doctors in your area who provide second opinions. (Medicare carriers are listed on pages 39 to 44.)

Services of Special Practitioners

Medicare Part B helps pay for covered services you receive from certain specially qualified practitioners who are not physicians. The practitioners must be approved by Medicare. Medicare-approved practitioners are listed below:

- Certified registered nurse anesthetist.
- Certified nurse midwife.
- Clinical psychologist.
- Clinical social worker (other than in a hospital).
- Physician assistant. (A physician assistant can furnish certain services in a hospital or certain other facilities, can serve as an assistant-at-surgery, and can furnish services in any location that is designated as a rural health professional shortage area.)
- Nurse practitioner and clinical nurse specialist in collaboration with a physician. (A nurse practitioner can furnish services in a skilled nursing facility or a Medicaid nursing facility in any area. In addition, a nurse practitioner or clinical nurse specialist can furnish services in a rural area.)

Outpatient Hospital Services

Medicare Part B helps pay for covered services you receive as an outpatient from a participating hospital for diagnosis or treatment of an illness or injury. Under certain conditions, Medicare helps pay for emergency outpatient care you receive from a non-participating hospital.

When you get outpatient hospital services, you are responsible for the annual Medicare Part B deductible. In addition to the deductible, you are responsible for a coinsurance of 20 percent of the hospital's charge above the deductible.

When you go to a hospital for outpatient services, you are sometimes asked how much of your Part B deductible you have met. One easy way to answer that question is to show your most recent *Explanation of Your Medicare Part B Benefits* notice. From this form, hospital staff can usually tell how much of the $100 annual deductible you have met.

If the hospital cannot tell how much of the $100 deductible you have met and the charge for the services you received is less than $100, the hospital may ask you to pay the entire bill. The amount you pay the hospital can be credited toward any part of the deductible you have not met. If you pay the hospital for deductible amounts you do not owe, the hospital or the Medicare intermediary will refund the amount you overpaid.

Major outpatient hospital services covered by Part B:

- Services in an emergency room or outpatient clinic, including same-day surgery.
- Laboratory tests billed by the hospital.
- Mental health care in a partial hospitalization psychiatric program, if a physician certifies that inpatient treatment would be required without it.
- X-rays and other radiology services billed by the hospital.
- Medical supplies such as splints and casts.
- Drugs and biologicals that cannot be self-administered.
- Blood transfusions furnished to you as an outpatient.

Some outpatient hospital services not covered by Part B:

- Routine physical examinations and tests directly related to such examinations (except some Pap smears and mammograms, see page 25).
- Eye or ear examinations to prescribe or fit eyeglasses or hearing aids.
- Most immunizations (See Drugs and Biologicals , page 26).
- Most routine foot care.

Other Services and Supplies Covered by Medicare

Ambulatory Surgical Services

An ambulatory surgical center is a facility that provides surgical services that do not require a hospital stay. Medicare Part B will pay for the use of an ambulatory surgical center for certain approved surgical procedures. However, by law Medicare can only pay centers that have an agreement with Medicare to participate in the Medicare program. If you do not know whether an ambulatory surgical center participates in Medicare, ask someone in the center's business office. If that person does not know, contact Social Security and ask them to check with the Health Care Financing Administration.

In addition to helping pay for the use of the ambulatory surgical center, Medicare also helps pay for physician

and anesthesia services that are provided in connection with the procedure.

Home Health Services

If you have both Medicare Part A and Part B, your Part A pays for home health services. But Part B will pay for home health services if you do not have Part A. Medicare home health services are described on page 18.

Outpatient Physical and OccupationalTherapy and Speech Pathology Services

Medicare Part B helps pay for medically necessary outpatient physical and occupational therapy or speech pathology services, if **all** the following three conditions are met:

1) Your doctor prescribes the service.
2) Your doctor or therapist sets up the plan of treatment.
3) Your doctor periodically reviews that plan.

You can receive physical therapy, occupational therapy or speech pathology services as an outpatient of a participating hospital or skilled nursing facility, or from a participating home health agency, rehabilitation agency, or public health agency. The provider of services may charge you only for any part of the $100 annual deductible you have not met, 20 percent of the remaining approved amount, and any noncovered services.

Also, you can receive services directly from an independently practicing, Medicare-approved physical or occupational therapist in his or her office or in your home if such treatment is prescribed by a doctor. (Medicare does not pay for services provided by independently practicing speech pathologists.) But, the maximum amount Medicare pays for each of these services provided by an independently practicing physical or occupational therapist in 1993 is $600 a year. (This is 80 percent of the maximum approved amount of up to $750.) The Medicare payment would be less than $600 if charges for these services are used to meet part or all of your $100 annual deductible.

Comprehensive Outpatient Rehabilitation Facility Services

Under certain circumstances, Medicare helps pay for outpatient services you receive from a Medicare-participating comprehensive outpatient rehabilitation facility (CORF). Covered services include physicians' services; physical, speech, occupational and respiratory therapies; counseling; and other related services. You must be referred by a physician who certifies that you need skilled rehabilitation services. For most CORF services, you are responsible only for the annual deductible and 20 percent of the Medicare approved-charges. Medicare helps pay for mental health treatment in a CORF; the Medicare payment limit for mental health treatment in a CORF is discussed on page 27.

Partial Hospitalization for Mental Health Treatment

Partial hospitalization (sometimes called day treatment) is a program of outpatient mental health care. Under certain conditions, Medicare Part B helps pay for these programs when provided by hospital outpatient departments or by community mental health centers. If you are considering mental health treatment, check with the program you have chosen to see if it meets the conditions for Medicare payment.

Rural Health Clinic Services

Medicare Part B helps pay for services of physicians, nurse practitioners, physician assistants, nurse midwives, visiting nurses (under certain conditions), clinical psychologists, and clinical social workers furnished by a rural health clinic. You are responsible only for the annual Medicare Part B deductible plus 20 percent of the Medicare-approved charge for the clinic.

Federally Qualified Health Center Services

Federally qualified health centers are located in both rural and urban areas and any Medicare beneficiary may seek services at them. As part of the "federally qualified health center benefit," Medicare Part B helps pay for services of physicians, nurse practitioners, physician assistants, nurse midwives, visiting nurses (under certain conditions), clinical psychologists, and clinical social workers. Also, as part of the federally qualified health center benefit, Medicare helps pay for certain preventive health services. The center can tell you what services are part of the federally qualified health center benefit.

You do **not** have to pay the Medicare Part B annual deductible for services provided under the federally qualified health center benefit. You **are** responsible for 20 percent of the Medicare-approved charge for the clinic. (There are some cases, under Public Health Service guidelines, when the federally qualified health center may waive all or part of the 20 percent Part B coinsurance which is applicable for center services.)

Federally qualified health centers often provide services **in addition** to those offered under the Medicare federally qualified health center benefit. Examples of these services are X-rays and equipment like crutches and canes. As long as the center meets Medicare requirements to provide these services, Medicare Part B can help pay for them. You are responsible for any unmet part of the annual Medicare Part B deductible plus 20 percent of the Medicare-approved charge for the service.

Laboratory Services

All laboratories must be certified under the Clinical Laboratory Improvement Amendments to perform laboratory testing. Medicare Part B pays the full approved fee for covered clinical diagnostic tests provided by certified laboratories that are participating in Medicare. The laboratory can be independent, part of a hospital outpatient department or in a doctor's office. The laboratory must accept assignment for the tests. (See page 28 for an explanation of assignment.) It may not bill you for the tests.*

Some laboratories are approved only for certain kinds of tests. Your doctor can usually tell you which laboratories are approved and whether the tests he or she is ordering from an approved laboratory are covered by Medicare. If your doctor can not tell you, call your Part B carrier. (Carriers are listed on pages 39 to 44.)

Portable Diagnostic X-ray Services

Medicare Part B helps pay for portable diagnostic X-ray services you receive in your home or other locations if they are ordered by a doctor and if they are provided by a Medicare-approved supplier. You can ask your Part B carrier whether the supplier is Medicare-approved. (Carriers are listed on pages 39 to 44.)

Other Diagnostic Tests

Medicare Part B also helps pay for other diagnostic tests, including X-rays, that your doctor orders to evaluate your medical problems.

Pap Smear Screening

Medicare Part B helps pay once every three years for Pap smears to screen for cervical cancer. Medicare helps pay more frequently for certain women at high risk. Medicare also pays for diagnostic Pap smears as needed when symptoms are present.

Breast-Cancer Screening (Mammography)

Medicare Part B helps pay for X-ray screenings for the detection of breast cancer, if they are provided by a Medicare-approved supplier. Women 65 or older can use the benefit every other year. Some younger women covered by Medicare can use the screening benefit more frequently. Your Medicare carrier can tell you how often Medicare will pay for a screening mammogram for you. Medicare also pays for diagnostic mammograms as needed when symptoms are present.

For accurate up-to-date information on cancer prevention, detection, diagnosis, and treatment for patients, their families, and the general public, call the Cancer Information Service at 1-800-4-CANCER.

Radiation Therapy

Medicare Part B helps pay for outpatient radiation therapy given under the supervision of your doctor.

Kidney Dialysis and Transplants

Medicare Part B helps pay for kidney dialysis and transplants. For detailed information on this coverage, you can get a copy of *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services* from the Consumer Information Center (see inside back cover).

Heart and Liver Transplants

Under certain limited conditions, Medicare Part B helps pay for heart and liver transplants in a Medicare-approved facility. If you are considering a heart or liver transplant, you and your physician can find out about Medicare coverage by contacting your Medicare carrier. If you belong to an HMO, the HMO will give you the information you need about Medicare coverage.

Ambulance Transportation

Medicare Part B helps pay for medically necessary ambulance transportation, including air ambulance, but only if:

- The ambulance, equipment and personnel meet Medicare requirements.
- Transportation in any other vehicle could endanger your health.

Under these conditions, Medicare helps pay for ambulance transportation but only to a hospital or skilled

*In the state of Maryland only, you may be charged 20 percent coinsurance for hospital outpatient tests.

nursing facility, or from a hospital or skilled nursing facility to your home. Medicare does **not** pay for ambulance use from your home to a doctor's office or to a dialysis facility that is not in or next to a hospital.

Medicare usually helps pay only if the ambulance transportation is in your local area. But, if there are no local facilities equipped to provide the care you need, Medicare helps pay for necessary ambulance transportation to the closest facility outside your local area that can provide the necessary care. If there is a local facility equipped to provide the care you need but you choose to go to another institution that is farther away, Medicare payment is based on the charge for transportation to the closest facility that can provide the necessary care.

Durable Medical Equipment

Medicare Part B helps pay for durable medical equipment such as oxygen equipment, wheelchairs, and other medically necessary equipment that your doctor prescribes for use in your home. (A hospital or facility that mainly provides skilled nursing or rehabilitation services cannot be considered your home.)

To be considered durable medical equipment, the equipment must be able to be used over again by other patients, must primarily serve a medical purpose, must not be useful to people who are not sick or injured, and must be appropriate for use in your home. Not all types of equipment that you might find useful can meet all four of these requirements.

Only your own doctor should prescribe medical equipment for you. An equipment supplier should not take any of the following actions:

- Contact you first, either by phone or by mail, and offer to get your doctor or Medicare to approve an item. (It is all right for the supplier to contact you in response to calls from your doctor or other health care workers.)
- Say he or she works for, or represents, Medicare.
- Deliver equipment to your home that neither you nor your doctor ordered.
- Send you used items, while billing Medicare for new ones.

Some of these actions may be against the law. If you believe a supplier has taken any of these actions, you should alert Medicare. First, ask your doctor whether he or she ordered the item. If your doctor did not order the item, you should file a complaint with your Medicare carrier. You can file a complaint by phone, in person or in writing. Your carrier will investigate.

It is also illegal for a supplier to offer you items at no cost to you or offer to pay the Medicare coinsurance on items. If a supplier makes one of these offers, file a complaint with your Medicare carrier as described above.

NOTE: The durable medical equipment supplier must have your doctor's prescription before delivering any of the following items: seat lift chairs, power-operated vehicles, equipment for care of pressure sores, or transcutaneous electrical nerve stimulators. **In the case of seat lift chairs, Medicare covers only the lift mechanism, not the chair itself.**

Medicare pays for different kinds of durable medical equipment in different ways; some equipment must be rented, other equipment must be purchased, and for some equipment you may choose rental or purchase. Your Medicare carrier will be able to provide more specific guidance on which method will be used for a particular item. (Carriers are listed on pages 39 to 44.)

Prosthetic Devices

Medicare Part B helps pay for prosthetic devices needed to replace an internal body organ. These include Medicare-approved corrective lenses needed after a cataract operation, ostomy bags and certain related supplies, and breast prostheses (including a surgical brassiere) after a mastectomy. Medicare also helps pay for artificial limbs and eyes, and for arm, leg, back, and neck braces. Medicare does **not** pay for orthopedic shoes unless they are an integral part of leg braces **and** the cost is included in the charge for the braces. Medicare does **not** pay for dental plates or other dental devices.

Medical Supplies

Medicare Part B helps pay for surgical dressings, splints, and casts ordered by a doctor in connection with your medical treatment. This does not include adhesive tape, antiseptics, or other common first-aid supplies.

Drugs and Biologicals

Pneumococcal Pneumonia Vaccine

Medicare Part B pays the full approved charges for pneumococcal pneumonia vaccine and its administration. Neither the $100 annual deductible nor the 20 percent coinsurance applies to this service.

Hepatitis B Vaccine

Medicare Part B helps pay for hepatitis B vaccine administered to beneficiaries considered to be at high or intermediate risk of contracting the disease.

Hemophilia Clotting Factors

Medicare Part B helps pay for blood clotting factors and items related to their administration for hemophilia patients who are able to use them to control bleeding without medical or other supervision. The amount of clotting factors necessary to have on hand for a specific period is determined for each patient individually.

Influenza Vaccine

Medicare Part B pays for influenza vaccine and its administration.

Blood

Medicare Part B helps pay for blood and blood components you receive as a hospital outpatient or as part of other services. (See page 21 for an explanation of the blood deductible.)

Antigens

Under certain circumstances, Medicare Part B helps pay for antigens prepared for you by your doctor. You can check with your Medicare carrier to see if Medicare will pay for your antigens. (Carriers are listed on pages 39 to 44.)

Immunosuppressive Drugs

Immunosuppressive drugs are often given to prevent rejection of transplanted organs. Medicare Part B helps pay for drugs used in immunosuppressive therapy for one year beginning with the date of discharge from the inpatient hospital stay during which a Medicare-covered organ transplant was performed.

Epoetin Alfa

Medicare Part B may help pay for the drug Epoetin alfa when used to treat Medicare beneficiaries with anemia related to chronic kidney failure, or related to use of AZT in HIV-positive beneficiaries or for other uses that a Medicare carrier finds medically appropriate. (The kidney failure patients are not required to be on dialysis.) The Epoetin alfa must be administered incident to the services of a doctor in the office or in a hospital outpatient department. Part B also helps pay for Epoetin alpha that is self-administered by home dialysis patients or administered by their caregivers.

Medicare Payments for Outpatient Treatment of Mental Illness

Medicare helps pay for outpatient mental health services you receive from professionals such as physicians, clinical psychologists, clinical social workers and other nonphysician practitioners. These professionals furnish services in various settings, for example, hospitals, comprehensive outpatient rehabilitation facilities, community mental health centers, and skilled nursing facilities.

When furnished on an outpatient basis, mental health treatment services are subject to a payment limitation that is called the "outpatient mental health limitation." In effect, once the annual deductible is met, Medicare Part B pays only 50 percent (not 80 percent) of the approved amount for these services. On assigned claims, beneficiaries are responsible for paying the remaining 50 percent. For unassigned claims, beneficiaries may have to pay more. (See page 28 for information about assignment.)

Partial hospitalization services (except those furnished by a physician) for treatment of mental illness are not subject to this payment limitation. Also, brief office visits for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental illness are not subject to this payment limitation. (See page 24 for more information about partial hospitalization services.)

Medicare Medical Insurance (Part B) Payments

The Assignment Payment Method

Under the assignment method, your doctor or supplier agrees to accept the amount approved by the Medicare carrier as total payment for covered services: the doctor or supplier agrees to "take assignment."

The assignment method can save you money. The doctor or supplier sends the claim to Medicare. Medicare pays your doctor or supplier 80 percent of the Medicare-approved amount, after subtracting any part of the $100 annual deductible you have not met. The doctor or supplier can charge you only for the part of the $100 annual deductible you have not met and for the coinsurance, which is the remaining 20 percent of the approved amount. Of course, your doctor or supplier also can charge you for services that Medicare does not cover.

Doctors and certain other practitioners and suppliers must take assignment on all claims for services furnished to Medicare beneficiaries who are eligible for medical assistance through their state Medicaid program, including Qualified Medicare Beneficiaries. (See 'Assistance for Low-Income Beneficiaries,' page 2.)

Participating Doctors and Suppliers

Doctors and suppliers may sign agreements to become **Medicare participating**. Medicare-participating doctors and suppliers have agreed in advance to accept assignment on all Medicare claims. Doctors and suppliers are given the opportunity to sign participation agreements each year. Medicare-participating doctors and suppliers can display emblems or certificates that show they accept assignment on all Medicare claims.

The names and addresses of Medicare-participating doctors and suppliers are listed (by geographic area) in the *Medicare-Participating Physician/Supplier Directory*. You can get the directory for your area free of charge from your Medicare carrier (see pages 39 to 44); or you can call your carrier and ask for names of some participating doctors and suppliers in your area. Also, this directory is available for you to use in Social Security offices, state and area offices of the Administration on Aging, and in most hospitals.

When Your Doctor Does Not Accept Assignment

If your doctor or supplier does not accept assignment, you must pay the doctor or supplier directly. You are usually responsible for the part of your bill that is more than the Medicare-approved amount since your doctor or supplier did not agree to accept the Medicare-approved amount as payment in full. In this case, Medicare pays you 80 percent of the approved amount, after subtracting any part of the $100 annual deductible you have not met.

Even though a doctor does not accept assignment, for most covered services, there are limits on the amount that he or she can actually charge you. In 1993, the most the doctor can charge you is 115 percent of what Medicare approves (see "Medicare Approved Amounts," page 29.) Doctors who charge more than these limits may be fined.

If you think you have been charged more than the limiting charge, ask the doctor for a reduction in the charge. If you have already paid more than the charge limit, ask for a refund. If you cannot get a reduction or refund, you can call your Medicare carrier and ask for assistance.

Some states have laws that could further reduce your medical costs. If you live in one of the states listed on page 50, you can ask the state office listed there about the laws in your state.

Three Payment Examples

The annual Part B deductible has been met

	Doctor's Bill	Medicare Approved Amount *	Medicare Pays	Beneficiary Responsible For
Doctor A accepts assignment	$480	$400	$320 (80% of approved amount)	$80 (20% of approved amount)
Doctor B does not accept assignment and charges no more than the limiting charge	$437	$380	$304 (80% of approved amount)	$133 (difference between the $437 actual charge–which is also the limiting charge–and Medicare payment)
Doctor C does not accept assignment and charges more than the limiting charge	$500	$380	$304 (80% of approved amount)	$133 (difference between the $437 limiting charge and Medicare payment)

* The Medicare approved amount is less for non-participating physicians than for participating physicians.

Special rule for doctors performing elective surgery: Medicare law requires doctors who do not take assignment for elective surgery to give you a written estimate of your costs before the surgery if the total charge for the surgical procedure is $500 or more. If the doctor did not give you a written estimate, you are entitled to a refund of any amount you paid him or her over the Medicare approved amount.

Many doctors and suppliers who do not take assignment on all claims may take assignment on some or most claims. Ask your doctor or supplier whether he or she will take assignment on your claims.

Three payment examples for the same service are shown above. Dr. A participates in the Medicare program and therefore accepts assignment on the claim. Drs. B and C do not participate and do not accept assignment. In all three examples, the beneficiary has already met the $100 deductible. Even though Dr. A's bill is not the lowest, the beneficiary pays the least for Dr. A's services. Also, even though Drs. B and C charge different amounts, the beneficiary pays the same amount because of the limiting charge.

Participating Providers

Hospitals, skilled nursing facilities, home health agencies, hospices, comprehensive outpatient rehabilitation facilities, and providers of outpatient physical and occupational therapy and speech pathology services are all participating providers under Medicare Part B. They submit their claims to Medicare. Medicare subtracts any deductible you have not met and any coinsurance amount and pays the provider. The provider bills you only for any deductible and coinsurance amounts you owe.

Medicare Approved Amounts

Medicare Part B payments are based for the most part on Medicare fee schedule amounts. The fee schedule for physicians and certain suppliers lists payments for each Part B service and takes into account geographic variation in the cost of practice. The fee schedule amount is often less than the actual charges billed by doctors and suppliers. Part B usually pays 80 percent of the fee schedule amount, even if it is less than the actual charge.

When a Part B claim is submitted, the carrier compares the actual charge shown on the claim with the fee schedule amount for that service. The Medicare-approved amount is the lower of the actual charge or the fee schedule amount.

Submitting Part B Claims

Doctors, Suppliers and Other Providers Must Submit Claims for You

Since September 1, 1990, doctors, suppliers and other providers of Part B services have in most cases been **required to submit Medicare claims for you,**

even if they do not take assignment. They must submit the claims within one year of providing the service to you or may be subject to certain penalties. (If you have other health insurance that should pay before Medicare, you can submit your claims yourself. See 'Filing Your Own Claims,' page 32.)

You should notify your Medicare carrier if your doctor or supplier refuses to submit a Part B Medicare claim for you if you believe the services may be covered by Medicare. (Phone numbers and addresses of carriers are listed on pages 39 to 44.)

How Does the Doctor or Supplier Submit Claims?

Your doctor or supplier must submit a form, called a HCFA-1500, requesting that Medicare Part B payment be made for your covered services, whether or not assignment is taken. The doctor or supplier completes the HCFA-1500 form and shows it to you. You sign the form and then the doctor or supplier sends it to the proper Medicare carrier.

If your claim is for the rental or purchase of durable medical equipment, a doctor's prescription, or certificate of medical necessity, must be included with the claim. The prescription must show the equipment you need, the medical reason for the need, and an estimate of how long the equipment will be medically necessary.

If You are Enrolled in a Coordinated Care Plan

If you are enrolled in a coordinated care plan—a prepaid health care organization such as an HMO—a claim will seldom need to be submitted on your behalf. Medicare pays the HMO a set amount and the HMO provides your medical care. In most cases, you are required to receive all non-emergency care through your HMO, or through arrangements they make before you receive care. However, if you get an out-of-plan service, the claim should be submitted directly to your HMO.

If your doctor or supplier needs an address, consult your HMO membership handbook, or contact the HMO.

Submitting Claims to the Railroad Retirement System

If you get Medicare under the Railroad Retirement system, the doctor or supplier must submit your claims to The Travelers Insurance Company office that serves your region. Regional offices of The Travelers are listed in *Your Medicare Handbook for Railroad Retirement Beneficiaries*, which is available at any Railroad Retirement office.

Explanation of Your Medicare Part B Benefits Notice

After your doctor, provider, or supplier sends in a Part B claim, Medicare will send you a notice called *Explanation of Your Medicare Part B Benefits* to tell you the decision on the claim. An illustration of the notice is shown on page 31.

The sample notice on page 31 is for services of a doctor and shows what charges were made and what Medicare approved. It shows what the co-payment is and what Medicare is paying. If the $100 annual deductible had not been met, that would also be shown. The notice gives the address and toll-free telephone number for contacting the carrier. Note that this doctor did not take assignment, so the limiting charge is shown. Notices for other Part B services are much like the ones for doctor services.

Please read your notices carefully. If you believe payments were made for services or supplies you didn't receive, or payments are otherwise questionable, call or write your carrier.

This is not a bill.

Explanation of Your Medicare PartB Benefits

JOHN D DOE
APARTMENT 12C
65 WOODLAWN DRIVE
BALTIMORE, MARYLAND 21207-1111

Your Medicare number is: 123-45-6789A

Summary of this notice dated June 1, 1992

Total charges:	$ 300.00
Total Medicare approved:	$ 180.00
We are paying you:	$ 144.00
Your total responsibility:	$ 216.00

Details about this notice (See the back for more information)

Control number 0000-0000-0000

You received these services from your provider: Elm Street Clinic, Mailing address: 123 Elm Street, Baltimore, Md. 21228

Services and Service Codes	Dates	Charge	Medicare Approved	Notes
Dr. Mary Smith				
3 office visits [00000]	May 01-08, 1992	$ 300.00	$ 180.00	a,b

Your provider did not accept assignment. We are paying you the amount that we owe you. See #4 on the back of this notice.

Notes:

a The approved amount is based on the fee schedule.

b Your doctor did not accept assignment for this service. Under federal law, your doctor cannot charge more than $216.00

Here's an explanation of this notice:

Of the total charges, Medicare approved	$180.00	See #4 on the back.
Less Medicare copayment amount	- 36.00	Your co-payment is 20%.
Amount after copay	$144.00	
We are paying you	$144.00	Please cash the enclosed check right away.
Of the total charges	$300.00	
Less amount exceeding charge limit	- 84.00	You are not responsible for this amount which is in excess of the Medicare limiting charge. See note b.
The total you are responsible for	$216.00	The provider may bill you for this amount.

IMPORTANT: If you have questions about this notice, call (carrier name) at (carrier telephone number) or see us at (carrier walk-in address). You will need this notice if you contact us.

To appeal our decision, you must WRITE to us before December 1, 1992. See #2 on the back.

Filing Your Own Claims

In some cases, you may need to file your own Medicare Part B claim. If you do, send the claim to the carrier responsible for processing Medicare claims in your area. No claims should be sent to the Health Care Financing Administration in Baltimore, Maryland.

To find out whether you need to file your own claim, call or write your Medicare carrier. (Carrier addresses and phone numbers are listed on pages 39 to 44.)

Time Limits

Under the law, there are time limits for submitting your own Medicare Part B claims. For Medicare to make payments on your claims, you must send in your claims within these time limits. You always have at least 15 months to submit claims. The table below tells you exactly what the time limits are.

For service you get between	Your claim must be submitted by
Oct 1, 1991 & Sept 30, 1992	Dec 31, 1993
Oct 1, 1992 & Sept 30, 1993	Dec 31, 1994
Oct 1, 1993 & Sept 30, 1994	Dec 31, 1995

Calling Your Medicare Carrier

Many carriers have installed an automated telephone answering system to help make their response to you faster and more accurate. When you call, if your carrier has a system of this type, you will be connected to a special automated voice system. If you have a touch-tone telephone, follow the instructions you receive over the phone to get information about the status of your claims.

If you need other information or want to talk about a claim, you can ask the system to connect you with a customer service representative at any time. **If you do not have a touch-tone telephone**, stay on the line after you dial and you will be connected to a customer service representative.

Claims for a Person Who Has Died

When a Medicare beneficiary dies, the way Medicare pays Part B claims depends on whether the doctor's or supplier's bill has been paid. (Any Part A payments due to the hospital, skilled nursing facility, home health agency or hospice will be made directly to the provider of services.)

If the bill was paid by the patient or with funds from the patient's estate, Medicare's payment will be made either to the estate representative or to a surviving member of the patient's immediate family. If someone other than the patient paid the bill, payment may be made to that person.

If the bill has **not** been paid and the doctor or supplier does not accept assignment, the Medicare payment can be made to the person who has or assumes legal obligation to pay the bill for the deceased patient.

Your Medicare carrier can provide additional information about how to claim a Medicare Part B payment after a patient dies.

Getting the Part of Medicare You Do Not Have

Getting Medicare Medical Insurance (Part B)

If you have Medicare premium-free Hospital Insurance but do not have Medicare Part B, you can sign up for Part B during a general enrollment period. A general enrollment period is held January 1 through March 31 each year. Your protection will begin July 1 of the year you enroll. If you enroll during a general enrollment period, your monthly premium may be increased by 10 percent for each 12-month period you could have had Part B but were not enrolled. (If you are covered under an employer group health plan based on current employment as described on this page, the premium penalty may be decreased or waived.)

Getting Medicare Hospital Insurance (Part A)

Some people 65 or older have Medicare Medical Insurance (Part B), but do not meet the requirements for premium-free Part A. If you are in this category, you can get Part A by paying a monthly premium. This is called "premium hospital insurance." The Part A premium is $221 a month through December 31, 1993. (This amount will change January 1, 1994.)

You can sign up for premium Part A during a general enrollment period: January 1 through March 31 each year. If you enroll during a general enrollment period that begins more than one year after you became eligible to buy Part A, your monthly premium may be 10 percent higher than the basic premium amount. Your protection will begin July 1 of the year you enroll. (Also see this page for information on the special enrollment period.)

If you have been covered under an HMO, you can sign up for premium Part A at any time while you are in the HMO and up to eight months after the HMO coverage has ended. The premium penalty, if any, may be reduced because of the coverage under the HMO.

For more information about premium amounts, premium surcharges, and how to get the part of Medicare you do not have, contact Social Security.

Special Enrollment Period

If you are covered by an employer group health plan based on your own or your spouse's current employment (not a plan for retired people and their spouses), you may be able to delay enrollment in Medicare Medical Insurance (Part B) or premium Hospital Insurance (Part A) without premium penalty and without waiting for a general enrollment period to enroll. Delayed enrollment without penalty or wait is usually available if you are covered by an employer group health plan at the time you are first able to get Medicare.

In general, if you are 65 or over, you may enroll in Medicare Part B during the seven-month period beginning with the month:

- Your or your spouse's current employment ends, or
- Your coverage under the employer group health plan ends, whichever comes first.

If you are disabled and covered by an employer group health plan, you are also given a special enrollment period in certain circumstances. If you are covered under a group health plan based on current employment status when you are first able to get Medicare, you may enroll in Medicare Part B during the seven-month period that begins:

- When the employment status ends,
- When the plan is no longer classifiable as a **large** group health plan (one that covers 100 or more employees), or
- When the plan coverage is terminated.

Contact Social Security as soon as employment ends, or the plan coverage ends or changes, to be sure that you get the information you need about enrolling in Medicare Part B.

Events That Can Change Your Medicare Protection

When Protection Ends for People 65 and Older

If you have Medicare Hospital Insurance (Part A) based on your spouse's work record, your protection will end if you and your spouse are divorced during the first 10 years of your marriage. But if you have Part A based on your **own** work record, your protection will continue as long as you live.

Your Medicare Part B protection will stop if your premiums are not paid or if you voluntarily cancel. If you are thinking about cancelling Part B, remember that you may not be able to get private insurance that offers the same protection. If you cancel Part B and then later decide to re-enroll, you will have to wait for a general enrollment period (January 1 through March 31 of each year). Also, your premium may be higher and your protection will not begin again until July 1 of the year you re-enroll. (If you are covered under an employer group health plan based on current employment as described on page 9, you may be eligible for a special enrollment period and the premium penalty may be decreased or waived as noted on page 33.)

If you are buying Medicare Part A by paying monthly premiums (see page 33), you will lose it if you cancel your Medicare Part B. People who buy Medicare Part A must also enroll and pay the premium for Part B. But, you can cancel Part A and still continue to buy Part B.

If you want more information about cancelling your Medicare protection, contact Social Security.

When Protection Ends for the Disabled

If you have Medicare because you are disabled, your protection will end if you recover from your disability before you are 65. If you work but are still disabled, your premium-free Part A protection will continue for at least 48 months after you begin working. Your Part B will also continue for at least 48 months if you continue to pay the monthly premiums.

If you remain disabled longer than 48 months after you return to work and lose your premium-free Part A (and your Part B) solely because you are working, you may buy Part A only or both Part A and Part B. (You cannot buy Part B only.) You can continue to buy Medicare as long as you remain disabled.

You may enroll during your initial enrollment period which begins with the month you are notified you are no longer eligible for premium-free Part A and continues for seven full months after that month. If you do not enroll during this initial enrollment period, you may enroll in a subsequent general enrollment period (January through March of each year) or during a special enrollment period (see page 33).

If you ever want to cancel the Medicare protection for which you pay premiums, contact Social Security.

When Protection Ends for Those With Permanent Kidney Failure

If you have Medicare because of permanent kidney failure, your protection will end 12 months after the month maintenance dialysis treatment stops or 36 months after the month you have a kidney transplant.

Your Medicare Part B protection could stop before that if you fail to pay the premiums, or if you decide to cancel. Call Social Security if you ever want to cancel your Part B protection.

If you need more information about Medicare coverage of permanent kidney failure, you can get a copy of *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services* from Social Security or the Consumer Information Center (see inside back cover).

How to Appeal Medicare Decisions

If you disagree with a decision on the amount Medicare will pay on a claim or whether services you received are covered by Medicare, you have the right to appeal the decision. The notice Medicare sends you tells you the decision made on the claim and exactly what appeal steps you can take. Appealing decisions by Part A providers, peer review organizations, intermediaries, carriers and health maintenance organizations are discussed below.

Appealing Decisions Made by Providers of Part A Services

In many cases the first written notice of noncoverage you receive will come from the provider of the services (for example, a hospital, skilled nursing facility, home health agency or hospice). This notice of noncoverage from the provider should explain why the provider believes Medicare will not pay for the services. This notice is not an official Medicare determination, but you can ask the provider to get an official Medicare determination. If you ask for an official Medicare determination, the provider must file a claim on your behalf to Medicare. Then you will receive a Notice of Utilization, which is the official Medicare determination. If you still disagree, you can appeal by following the instructions on the Notice of Utilization.

Appealing Decisions Made by Peer Review Organizations (PROs)

When you are admitted to a Medicare-participating hospital, you will be given a notice called *An Important Message From Medicare*. The notice contains a brief description of PROs, and the name, address and phone number of the PRO in your state. Also, it describes your appeal rights.

PROs make determinations mainly about inpatient hospital care and ambulatory surgical center care. The PROs decide whether care provided to Medicare patients is medically necessary, provided in the most appropriate setting, and is of good quality. When you disagree with a PRO decision about your case, you can appeal by requesting a reconsideration. Then, if you disagree with the PRO's reconsideration decision, and the amount remaining in question is $200 or more, you can request a hearing by an Administrative Law Judge. Cases involving $2,000 or more can eventually be appealed to a Federal Court.

If you belong to a Medicare health maintenance organization (HMO), the HMO will usually make decisions about the medical necessity, the appropriateness of setting and the quality of your care. In most cases, you do not have the right to appeal to the PRO, but you always have the right to register complaints about the quality of your hospital care to the PRO. (See page 36 for more information about appeal rights for members of HMOs.)

NOTE: In the case of elective (non-emergency) surgery, either the hospital or the PRO may be involved in pre-admission decisions. If the hospital believes that your proposed stay will not be covered by Medicare, it may recommend, without consulting the PRO, that you not be admitted to the hospital. If this is the case, the hospital must give you its decision in writing. If you or your doctor disagree with the hospital's decision, you should make a request to the PRO for immediate review. If you want an immediate review, you must make your request, by telephone or in writing, within three calendar days after receipt of the notice.

Appealing Decisions of Intermediaries on Part A Claims

Appeals of decisions on most other services covered under Medicare Part A (skilled nursing facility care, home health care, hospice services, and a few inpatient hospital matters not handled by PROs) are handled by Medicare intermediaries. If you disagree with the intermediary's initial decision, you have 60 days from the date you receive the initial decision to request a reconsideration. The request can be submitted directly to the intermediary or through Social Security. If you disagree with the intermediary's reconsideration decision and the amount remaining in question is $100 or more, you have 60 days from the date you receive the reconsideration decision to request a hearing by an Administrative Law Judge. Cases involving $1,000 or more can eventually be appealed to a Federal Court.

Appealing Decisions Made by Carriers on Part B Claims

If you disagree with Medicare's decision on a Part B claim, you have the right to appeal that decision. You have six months from the date of the decision to ask the carrier to review it. Then, if you disagree with the carrier's written explanation of its review decision and the amount remaining in question is $100 or more, you have six months from the date of the review decision to request a hearing before a carrier hearing officer. You may combine claims that have been reviewed or re-opened so long as all claims combined are at the proper level of appeal and the appeal for each claim combined is filed on time.

If you disagree with the carrier hearing officer's decision and the amount remaining in question is $500 or more, you have 60 days from the date you receive the decision to request a hearing before an Administrative Law Judge. You may combine claims that have had a carrier hearing officer's decision so long as the appeal for each claim combined is filed within 60 days of the date you received the carrier hearing decision for that claim. Cases involving $1,000 or more can eventually be appealed to a Federal Court.

Appealing Decisions Made by Health Maintenance Organizations (HMOs)

If you have Medicare coverage through an HMO, decisions about coverage and payment for services will usually be made by your HMO. When your HMO makes a decision to deny payment for Medicare-covered services or refuses to provide Medicare-covered supplies you request, you will be given a *Notice of Initial Determination.* Along with the notice, your HMO is required to provide a full, written explanation of your appeal rights.

If you believe that the decision your HMO made was not correct, you have the right to ask for a reconsideration. You must file your request for reconsideration within 60 days after you receive the *Notice of Initial Determination.* Your request must be in writing. You may mail it or deliver it personally to your HMO or to a Social Security office (or the Railroad Retirement Board if you get Medicare through Railroad Retirement).

Your HMO is responsible for reconsidering its initial determination to deny payment or services. If your HMO does not rule fully in your favor, the HMO must send your reconsideration request to the Health Care Financing Administration (HCFA) for a review and determination.

If you disagree with HCFA's decision, and the amount in question is $100 or more, you have 60 days from receipt of HCFA's decision to request a hearing before an Administrative Law Judge. Cases involving $1,000 or more can eventually be appealed to a Federal Court.

For More Information

If you need more information about your right to appeal and how to request it, call Social Security, or the Medicare intermediary or carrier in your state. (The number of the Medicare intermediary or carrier is listed on the notice explaining Medicare's decision on the claim. Medicare carriers are also listed on pages 39 to 44.) If you need more information about your right to appeal a Peer Review Organization (PRO) decision, you can call the PRO in your state. (PROs are listed on pages 45 to 49).

MEDICARE (PART A): HOSPITAL INSURANCE-COVERED SERVICES FOR 1993

Services	Benefit	Medicare Pays	You Pay
HOSPITALIZATION Semiprivate room and board, general nursing and miscellaneous hospital services and supplies. (Medicare payments based on benefit periods, see page 14).	First 60 days	All but $676	$676
	61st to 90th day	All but $169 a day	$169 a day
	91st to 150th day[1]	All but $338 a day	$338 a day
	Beyond 150 days	Nothing	All costs
SKILLED NURSING FACILITY CARE You must have been in a hospital for at least 3 days and enter a Medicare-approved facility generally within 30 days after hospital discharge.[2] (Medicare payments based on benefit periods, see page 14.)	First 20 days	100% of approved amount	Nothing
	Additional 80 days	All but $84.50 a day	$84.50 a day
	Beyond 100 days	Nothing	All costs
HOME HEALTH CARE Medically necessary skilled care.	Part-time or intermittent care for as long as you meet Medicare conditions.	100% of approved amount; 80% of approved amount for durable medical equipment.	Nothing for services; 20% of approved amount for durable medical equipment.
HOSPICE CARE Pain relief, symptom management and support services for the terminally ill.	If you elect the hospice option and as long as doctor certifies need.	All but limited costs for outpatient drugs and inpatient respite care.	Limited cost sharing for outpatient drugs and inpatient respite care.
BLOOD	Unlimited if medically necessary.	All but first 3 pints per calendar year.	For first 3 pints.[3]

1993 Part A monthly premium: None for most beneficiaries.
$221 if you must buy Part A (Premium may be higher if you enroll late).

[1] This 60-reserve-days benefit may be used only once in a lifetime (see page 15).
[2] Neither Medicare nor private Medigap insurance will pay for most nursing home care (see page 17).
[3] To the extent the blood deductible is met under Part B of Medicare during the calendar year, it does not have to be met under Part A.

MEDICARE (PART B): MEDICAL INSURANCE-COVERED SERVICES FOR 1993

Services	Benefit	Medicare Pays	You Pay
MEDICAL EXPENSES Doctors' services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, ambulance, diagnostic tests, and more.	Medicare pays for medical services in or out of the hospital.	80% of approved amount (after $100 deductible).	$100 deductible,[1] plus 20% of approved amount and limited charges above approved amount.[2]
CLINICAL LABORATORY SERVICES Blood tests, urinalyses, and more.	Unlimited if medically necessary.	100% of approved amount.	Nothing for services.
HOME HEALTH CARE Medically necessary skilled care.	Part-time or intermittent skilled care for as long as you meet conditions for benefits.	100% of approved amount; 80% of approved amount for durable medical equipment.	Nothing for services; 20% of approved amount for durable medical equipment.
OUTPATIENT HOSPITAL TREATMENT Services for the diagnosis or treatment of illness or injury.	Unlimited if medically necessary.	Medicare payment to hospital based on hospital cost.	$100 deductible, plus 20% of billed charges.
BLOOD	Unlimited if medically necessary.	80% of approved amount (after $100 deductible and starting with 4th pint).	First 3 pints plus 20% of approved amount for additional pints (after $100 deductible).[3]

1993 Part B monthly premium: $36.60 (Premium may be higher if you enroll late).

[1] Once you have had $100 of expenses for covered services in 1993, the Part B deductible does not apply to any further covered services you receive for the rest of the year.

[2] See 'When Your Doctor Does Not Accept Assignment,' page 28.

[3] To the extent the blood deductible is met under Part A of Medicare during the calendar year, it does not have to be met under Part B.

MEDICARE CARRIERS

Carriers can answer questions about Medical Insurance (Part B)

Note:
— **The toll-free or 800 numbers listed below, in many cases, can be used only in the states where the carriers are located.** Also listed are the local commercial numbers for the carriers. Out-of-state callers may use the commercial numbers.
— These carrier toll-free numbers are for beneficiaries to use and should not be used by doctors and suppliers.
— Many carriers have installed an automated telephone answering system. If you have a touch-tone telephone, you can follow the system instructions to find out about your latest claims and get other information. If you do not have a touch-tone telephone, stay on the line and someone will help you.

ALABAMA
Medicare/Blue Cross-Blue Shield of Alabama
P.O. Box 83140
Birmingham, Alabama 35282
1-800-292-8855
205-988-2244

ALASKA
Medicare/Aetna Life Insurance Company
200 S.W. Market St.,
P.O. Box 1998
Portland, Oregon 97207-1998
1-800-452-0125 (toll-free: Alaska to Oregon customer service site)
503-222-6831 (customer service site in Oregon)

ARIZONA
Medicare/Aetna Life Insurance Company
P.O. Box 37200
Phoenix, Arizona 85069
1-800-352-0411
602-861-1968

ARKANSAS
Medicare/Arkansas Blue Cross and Blue Shield
P.O. Box 1418
Little Rock, Arkansas 72203-1418
1-800-482-5525
501-378-2320

CALIFORNIA
Counties of: Los Angeles, Orange, San Diego, Ventura, Imperial, San Luis Obispo, Santa Barbara
Medicare/Transamerica Occidental Life Insurance Co.
Box 30540
Los Angeles, California 90030-0540
1-800-675-2266
213-748-2311
Rest of state: Medicare Claims Dept.
Blue Shield of California
Chico, California 95976
(In area codes 209, 408,415, 707, 916)
1-800-952-8627
916-743-1583
(In the following area codes—**other than Los Angeles, Orange, San Diego, Ventura, Imperial, San Luis Obispo, and Santa Barbara counties**—213, 619, 714, 805, 818)
1-800-848-7713
714-796-9393

COLORADO
Medicare/Blue Cross and Blue Shield of Colorado
Coordination of Benefits:
P.O. Box 173550
Denver, Colorado 80217
Correspondence/Appeals:
P.O. Box 173500
Denver, Colorado 80217
(Metro Denver) 303-831-2661
(In Colorado, outside of metro area) 1-800-332-6681

CONNECTICUT
Medicare/The Travelers Companies
538 Preston Avenue
P.O. Box 9000
Meriden, Connecticut 06454-9000
1-800-982-6819
(In Hartford) 203-728-6783
(In the Meriden area) 203-237-8592

DELAWARE
Medicare/Pennsylvania Blue Shield
P.O. Box 890200
Camp Hill, Pennsylvania 17089-0200
1-800-851-3535

DISTRICT OF COLUMBIA
Medicare/Pennsylvania Blue Shield
P.O. Box 890100
Camp Hill, Pennsylvania 17089-0100
1-800-233-1124

FLORIDA
Medicare/Blue Cross and Blue Shield of Florida, Inc.
P.O. Box 2360
Jacksonville, Florida 32231
For fast service on simple inquiries including requests for copies of Explanation of Your Medicare Part B Benefits notices, requests for MEDPAR directories, brief claims inquiries (status or verification of receipt), and address changes:
1-800-666-7586
904-355-8899
For all your other Medicare needs:
1-800-333-7586
904-355-3680

MEDICARE CARRIERS

Carriers can answer questions about Medical Insurance (Part B)

GEORGIA
Medicare/Aetna Life Insurance Company
P.O. Box 3018
Savannah, Georgia 31402-3018
1-800-727-0827
912-920-2412

HAWAII
Medicare/Aetna Life Insurance Company
P.O. Box 3947
Honolulu, Hawaii 96812
1-800-272-5242
808-524-1240

IDAHO
Connecticut General Life Insurance Company
3150 N. Lakeharbor Lane, Suite 254
P.O. Box 8048
Boise, Idaho 83707-6219
1-800-627-2782
208-342-7763

ILLINOIS
Medicare Claims/Health Care Service Corporation
P.O. Box 4422
Marion, Illinois 62959
1-800-642-6930
312-938-8000

INDIANA
Medicare Part B/AdminaStar Federal
P.O. Box 7073
Indianapolis, Indiana 46207
1-800-622-4792
317-842-4151

IOWA
Medicare/IASD Health Services Corporation
(d/b/a Blue Cross & Blue Shield of Iowa)
636 Grand
Des Moines, Iowa 50309
1-800-532-1285
515-245-4785

KANSAS
The counties of Johnson and Wyandotte:
Medicare/Blue Cross and Blue Shield of Kansas, Inc.
P.O. Box 419840
Kansas City, Missouri 64141-6840
1-800-892-5900
816-561-0900
Rest of state: Medicare/Blue Cross and Blue Shield of Kansas, Inc.
1133 S.W. Topeka Boulevard
Topeka, Kansas 66629-0001
1-800-432-3531
913-232-3773

KENTUCKY
Medicare-Part B/Blue Cross & Blue Shield of Kentucky, Inc.
100 East Vine St.
Lexington, Kentucky 40507
1-800-999-7608
606-233-1441

LOUISIANA
Arkansas Blue Cross & Blue Shield, Inc.
Medicare Administration
P.O. Box 83830
Baton Rouge, Louisiana 70884-3830
1-800-462-9666
(In New Orleans) 504-529-1494
(In Baton Rouge) 504-927-3490

MAINE
Medicare/C and S Administrative Services
P.O. Box 1000
Hingham, Massachusetts 02044-9191
For Non-assigned Claims:
P.O. Box 2222
Hingham, Massachusetts 02044-9193
1-800-492-0919
207-828-4300

MARYLAND
Counties of: Montgomery, Prince Georges
Medicare/Pennsylvania Blue Shield
P.O. Box 890100
Camp Hill, Pennsylvania 17089-0100
1-800-233-1124
Rest of state: Blue Cross and Blue Shield of Maryland, Inc.
1946 Greenspring Drive
Timonium, Maryland 21093
1-800-492-4795
410-561-4160

MEDICARE CARRIERS

Carriers can answer questions about Medical Insurance (Part B)

MASSACHUSETTS
Medicare/C and S Administrative Services
P.O. Box 1000
Hingham, Massachusetts 02044-9191
For Non-assigned Claims:
P.O. Box 2222
Hingham, Massachusetts 02044-9193
1-800-882-1228
617-741-3300

MICHIGAN
Medicare Part B
Blue Cross & Blue Shield of Michigan
P.O. Box 2201
Detroit, Michigan 48231-2201
313-225-8200
1-800-482-4045

MINNESOTA
Counties of: Anoka, Dakota, Fillmore,
Goodhue, Hennepin, Houston, Olmstead,
Ramsey, Wabasha, Washington, Winona
Medicare/The Travelers Ins. Co.
8120 Penn Avenue South
Bloomington, Minnesota 55431
1-800-352-2762
612-884-7171
Rest of state: Medicare/Blue Cross and Blue Shield of Minnesota
P.O. Box 64357
St. Paul, Minnesota 55164
1-800-392-0343
612-456-5070

MISSISSIPPI
Medicare/The Travelers Ins. Co.
P.O. Box 22545
Jackson, Mississippi 39225-2545
1-800-682-5417
601-956-0372

MISSOURI
Counties of: Andrew, Atchison, Bates,
Benton, Buchanan, Caldwell, Carroll, Cass,
Clay, Clinton, Daviess, DeKalb, Gentry,
Grundy, Harrison, Henry, Holt, Jackson, Johnson, Lafayette,
Livingston, Mercer, Nodaway, Pettis, Platte, Ray, St. Clair,
Saline, Vernon, Worth
Medicare/Blue Cross and Blue Shield of Kansas, Inc.
P.O. Box 419840
Kansas City, Missouri 64141-6840
1-800-892-5900
816-561-0900
Rest of state: Medicare
General American Life Insurance Co.
P.O. Box 505
St. Louis, Missouri 63166
1-800-392-3070
314-843-8880

MONTANA
Medicare/Blue Cross and Blue Shield of Montana, Inc.
2501 Beltview
P.O. Box 4310
Helena, Montana 59604
1-800-332-6146
406-444-8350

NEBRASKA
The carrier for Nebraska is Blue Cross and Blue Shield of Kansas, Inc. Claims, however, should be sent to:
Medicare Part B
Blue Cross/Blue Shield of Nebraska
P.O. Box 3106
Omaha, Nebraska 68103-0106
1-800-633-1113
913-232-3773 (customer service site in Kansas)

NEVADA
Medicare/Aetna Life Insurance Company
P.O. Box 37230
Phoenix, Arizona 85069
1-800-528-0311
602-861-1968

NEW HAMPSHIRE
Medicare/C and S Administrative Services
P.O. Box 1000
Hingham, Massachusetts 02044-9191
For Non-assigned Claims:
P.O. Box 2222
Hingham, Massachusetts 02044-9193
1-800-447-1142
207-828-4300

MEDICARE CARRIERS

Carriers can answer questions about Medical Insurance (Part B)

NEW JERSEY
Medicare/Pennsylvania Blue Shield
P.O. Box 400010
Harrisburg, Pennsylvania 17140-0010
1-800-462-9306
717-975-7333

NEW MEXICO
Medicare/Aetna Life Insurance Company
P.O. Box 25500
Oklahoma City, Oklahoma 73125-0500
1-800-423-2925
(In Albuquerque) 505-821-3350

NEW YORK

Counties of: Bronx, Columbia, Delaware, Dutchess, Greene, Kings, Nassau, New York, Orange, Putnam, Richmond, Rockland, Suffolk, Sullivan, Ulster, Westchester
Medicare B/Empire Blue Cross and Blue Shield
P.O. Box 2280
Peekskill, New York 10566
1-800-442-8430
516-244-5100
County of: Queens
Medicare/Group Health, Inc.
P.O. Box 1608, Ansonia Station
New York, New York 10023
212-721-1770
Rest of state:
Blue Shield of Western New York
Upstate Medicare Division–Part B
7-9 Court Street
Binghamton, New York 13901-3197
607-772-6906
1-800-252-6550

NORTH CAROLINA
Connecticut General Life Insurance Company
P.O. Box 671
Nashville, Tennessee 37202
1-800-672-3071
919-665-0348

NORTH DAKOTA
Medicare/Blue Shield of North Dakota
4510 13th Avenue, S.W.
Fargo, North Dakota 58121-0001
1-800-247-2267
701-282-0691

OHIO
Medicare/Nationwide Mutual Ins. Co.
P.O. Box 57
Columbus, Ohio 43216
1-800-282-0530
614-249-7157

OKLAHOMA
Medicare/Aetna Life Insurance Company
701 N.W. 63rd St.
Oklahoma City, Oklahoma 73116-7693
1-800-522-9079
405-848-7711

OREGON
Medicare/Aetna Life Insurance Company
200 S.W. Market St.
P.O. Box 1997
Portland, Oregon 97207-1997
1-800-452-0125
503-222-6831

PENNSYLVANIA
Medicare/Pennsylvania Blue Shield
P.O. Box 890065
Camp Hill, Pennsylvania 17089-0065
1-800-382-1274
717-763-3601

RHODE ISLAND
Medicare/ Blue Cross and Blue Shield of Rhode Island
Inquiry Department
444 Westminster Street
Providence, Rhode Island 02903-3279
1-800-662-5170
401-861-2273

SOUTH CAROLINA
Medicare Part B
Blue Cross and Blue Shield of South Carolina
P. O. Box 100190
Columbia, South Carolina 29202
1-800-868-2522
803-788-3882

SOUTH DAKOTA
Medicare Part B/Blue Shield of North Dakota
4510 13th Avenue, S.W.
Fargo, North Dakota 58121-0001
1-800-437-4762
701-282-0691

MEDICARE CARRIERS

Carriers can answer questions about Medical Insurance (Part B)

TENNESSEE
Connecticut General Life Insurance Company
P.O. Box 1465
Nashville, Tennessee 37202
1-800-342-8900
615-244-5650

TEXAS
Medicare/Blue Cross & Blue Shield of Texas, Inc.
P.O. Box 660031
Dallas, Texas 75266-0031
1-800-442-2620
214-235-3433

UTAH
Medicare/Blue Shield of Utah
P.O. Box 30269
Salt Lake City, Utah 84130-0269
1-800-426-3477
801-481-6196

VERMONT
Medicare/C and S Administrative Services
P.O. Box 1000
Hingham, Massachusetts 02044-9191
For Non-assigned Claims:
P.O. Box 2222
Hingham, Massachusetts 02044-9193
1-800-447-1142
207-828-4300

VIRGINIA
Counties of: Arlington, Fairfax;
Citys of: Alexandria, Falls Church, Fairfax
Medicare/Pennsylvania Blue Shield
P.O. Box 890100
Camp Hill, Pennsylvania 17089-0100
1-800-233-1124
717-763-3601
Rest of state: Medicare/The Travelers Ins. Co.
P.O. Box 26463
Richmond, Virginia 23261
1-800-552-3423
804-330-4786

WASHINGTON
Medicare
King County Medical Blue Shield
P.O. Box 91070
Seattle, Washington 98111-9170
(In Seattle) 1-800-422-4087
206-464-3711
(In Spokane) 1-800-572-5256
509-536-4550
(In Tacoma) 206-597-6530

WEST VIRGINIA
Medicare/Nationwide Mutual Insurance Co.
P.O. Box 57
Columbus, Ohio 43216
1-800-848-0106
614-249-7157

WISCONSIN
Medicare/WPS
Box 1787
Madison, Wisconsin 53701
1-800-944-0051
(In Madison) 608-221-3330

WYOMING
Blue Cross and Blue Shield of North Dakota
P.O. Box 628
Cheyenne, Wyoming 82003
1-800-442-2371
307-632-9381

AMERICAN SAMOA
Medicare/Aetna Life Insurance Company
P.O. Box 3947
Honolulu, Hawaii 96812
808-524-1240

GUAM
Medicare/Aetna Life Insurance Company
P.O. Box 3947
Honolulu, Hawaii 96812
808-524-1240

NORTHERN MARIANA ISLANDS
Medicare/Aetna Life Insurance Company
P.O. Box 3947
Honolulu, Hawaii 96812
808-524-1240

MEDICARE CARRIERS

Carriers can answer questions about Medical Insurance (Part B)

PUERTO RICO
Medicare/Seguros De Servicio De
Salud De Puerto Rico
Call Box 71391
San Juan, Puerto Rico 00936

(In Puerto Rico)	800-462-7015
(In U.S. Virgin Islands)	800-474-7448
(In Puerto Rico metro area)	809-749-4900

VIRGIN ISLANDS
Medicare/Seguros De Servicio De
Salud De Puerto Rico
Call Box 71391
San Juan, Puerto Rico 00936

(In U.S. Virgin Islands)	800-474-7448

MEDICARE PEER REVIEW ORGANIZATIONS (PROs)

PROs can answer questions about hospital stays and other Hospital Insurance (Part A) services. Do not call the PRO with questions about Medicare Medical Insurance (Part B).

ALABAMA
Alabama Quality Assurance Foundation, Inc.
Suite 600
600 Beacon Parkway West
Birmingham, AL 35209-3154
1-800-288-4992

ALASKA
Professional Review Organization for Washington
(PRO for Alaska)
Suite 100
10700 Meridian Avenue, North
Seattle, WA 98133-9008
1-800-445-6941
(in Anchorage dial 562-2252)

AMERICAN SAMOA and GUAM
(see Hawaii)

ARIZONA
Health Services Advisory Group, Inc.
P.O. Box 16731
Phoenix, AZ 85011-6731
1-800-626-1577
(in Arizona dial 1-800-359-9909 or 1-800-223-6693)

ARKANSAS
Arkansas Foundation for Medical Care, Inc.
P.O. Box 2424
809 Garrison Avenue
Fort Smith, AR 72902
1-800-824-7586
(in Arkansas dial 1-800-272-5528)

CALIFORNIA
California Medical Review, Inc.
Suite 500
60 Spear Street
San Francisco, CA 94105
1-800-841-1602 (in-state only)
1-415-882-5800*

COLORADO
Colorado Foundation for Medical Care
1260 South Parker Road
P.O. Box 17300
Denver, CO 80217-0300
1-800-727-7086 (in-state only)
1-303-695-3333*

CONNECTICUT
Connecticut Peer Review Organization, Inc.
100 Roscommon Drive, Suite 200
Middletown, CT 06457
1-800-553-7590 (in-state only)
1-203-632-2008*

DELAWARE
West Virginia Medical Institute, Inc.
(PRO for Delaware)
3001 Chesterfield Place
Charleston, WV 25304
1-800-642-8686 ext. 266
(in Wilmington dial 655-3077)

DISTRICT OF COLUMBIA
Delmarva Foundation for Medical Care, Inc.
(PRO for D.C.)
9240 Centreville Road
Easton, MD 21601
1-800-645-0011
(in Maryland dial 1-800-492-5811)

FLORIDA
Florida Medical Quality Assurance, Inc.
Suite 700
1211 North Westshore Boulevard
Tampa, FL 33607
1-800-844-0795
813-281-9024

GEORGIA
Georgia Medical Care Foundation
Suite 200
57 Executive Park South
Atlanta, GA 30329
1-800-282-2614 (in-state only)
404-982-0411

*PRO will accept collect calls from out of state on this number.

MEDICARE PEER REVIEW ORGANIZATIONS (PROs)

PROs can answer questions about hospital stays and other Hospital Insurance (Part A) services. Do not call the PRO with questions about Medicare Medical Insurance (Part B).

HAWAII
Hawaii Medical Service Association
(PRO for American Samoa/Guam and Hawaii)
818 Keeaumoku Street
P.O. Box 860
Honolulu, HI 96808-0860
1-808-944-3586*

IDAHO
Professional Review Organization for Washington
(PRO for Idaho)
Suite 100
10700 Meridian Avenue, North
Seattle, WA 98133-9008
1-800-445-6941
1-208-343-4617* (local Boise and collect)

ILLINOIS
Crescent Counties Foundation for Medical Care
280 Shuman Boulevard, Suite 240
Naperville, IL 60563
1-800-647-8089

INDIANA
Indiana Medical Review Organization
2901 Ohio Boulevard
P.O. Box 3713
Terre Haute, IN 47803
1-800-288-1499

IOWA
Iowa Foundation for Medical Care
Suite 350E
6000 Westown Parkway
West Des Moines, IA 50266-7771
1-800-752-7014
515-223-2900

KANSAS
The Kansas Foundation for Medical Care, Inc.
2947 S.W. Wanamaker Drive
Topeka, KS 66614
1-800-432-0407 (in-state only)
913-273-2552

KENTUCKY
Kentucky Medical Review Organization
10503 Timberwood Circle, Suite 200
P.O. Box 23540
Louisville, KY 40223
1-800-288-1499

LOUISIANA
Louisiana Health Care Review, Inc.
8591 United Plaza Blvd., Suite 270
Baton Rouge, LA 70809
1-800-433-4958 (in-state only)
504-926-6353

MAINE
Health Care Review, Inc.
(PRO for Maine)
Henry C. Hall Building
345 Blackstone Blvd.
Providence, RI 02906
1-800-541-9888 or 1-800-528-0700 (both numbers in Maine only)
1-207-945-0244*

MARYLAND
Delmarva Foundation for Medical Care, Inc.
(PRO for Maryland)
9240 Centreville Road
Easton, MD 21601
1-800-645-0011
(in Maryland dial 1-800-492-5811)

MASSACHUSETTS
Massachusetts Peer Review Organization, Inc.
300 Bearhill Road
Waltham, MA 02154
1-800-252-5533 (in-state only)
1-617-890-0011*

MICHIGAN
Michigan Peer Review Organization
40600 Ann Arbor Road, Suite 200
Plymouth, MI 48170
1-800-365-5899

MINNESOTA
Foundation for Health Care Evaluation
Suite 400
2901 Metro Drive
Bloomington, MN 55425
1-800-444-3423

*PRO will accept collect calls from out of state on this number.

MEDICARE PEER REVIEW ORGANIZATIONS (PROs)

PROs can answer questions about hospital stays and other Hospital Insurance (Part A) services. Do not call the PRO with questions about Medicare Medical Insurance (Part B).

MISSISSIPPI
Mississippi Foundation for Medical Care, Inc.
P.O. Box 4665
735 Riverside Drive
Jackson, MS 39296-4665
1-800-844-0600 (in-state only)
601-948-8894

MISSOURI
Missouri Patient Care Review Foundation
505 Hobbs Road, Suite 100
Jefferson City, MO 65109
1-800-347-1016

MONTANA
Montana-Wyoming Foundation for Medical Care
400 North Park, 2nd Floor
Helena, MT 59601
1-800-332-3411 (in-state only)
1-406-443-4020*

NEBRASKA
The Sunderbruch Corporation–NE
1221 "N" Street, Suite 800
Lincoln, NE 68508
1-800-247-3004 (in-state only)
1-402-474-7471*

NEVADA
Nevada Peer Review
675 East 2100 South, Suite 270
Salt Lake City, UT 84106-1864
1-800-558-0829 (in Nevada only)
(in Reno dial 1-702-826-1996)
1-702-385-9933*

NEW HAMPSHIRE
New Hampshire Foundation for Medical Care
15 Old Rollinsford Road, Suite 302
Dover, NH 03820
1-800-582-7174 (in-state only)
1-603-749-1641*

NEW JERSEY
The Peer Review Organization of New Jersey, Inc.
Central Division
Brier Hill Court, Building J
East Brunswick, NJ 08816
1-800-624-4557 (in-state only)
1-201-238-5570*

NEW MEXICO
New Mexico Medical Review Association
707 Broadway N.E., Suite 200
P.O. Box 27449
Albuquerque, NM 87125-7449
1-800-432-6824 (in-state only)
505-842-6236
(In Albuquerque dial 842-6236)

NEW YORK
Island Peer Review Organization, Inc.
1979 Marcus Avenue, First floor
Lake Success, NY 11042
1-800-331-7767
1-516-326-7767*

NORTH CAROLINA
Medical Review of North Carolina
Suite 200
P.O. Box 37309
1011 Schaub Drive
Raleigh, NC 27627
1-800-682-2650 (in-state only)
919-851-2955

NORTH DAKOTA
North Dakota Health Care Review, Inc.
Suite 301
900 North Broadway
Minot, ND 58701
1-800-472-2902 (in-state only)
1-701-852-4231*

OHIO
Peer Review Systems, Inc.
Suite 250
3700 Corporate Drive
Columbus, OH 43231-7990
1-800-233-7337

*PRO will accept collect calls from out of state on this number.

MEDICARE PEER REVIEW ORGANIZATIONS (PROs)

PROs can answer questions about hospital stays and other Hospital Insurance (Part A) services. Do not call the PRO with questions about Medicare Medical Insurance (Part B).

OKLAHOMA
Oklahoma Foundation for Peer Review, Inc.
Suite 400 The Paragon Building
5801 Broadway Extension
Oklahoma City, OK 73118-7489
1-800-522-3414 (in-state only)
405-840-2891

OREGON
Oregon Medical Professional Review Organization
Suite 200
1220 Southwest Morrison
Portland, OR 97205
1-800-344-4354 (in-state only)
503-279-0100*

PENNSYLVANIA
Keystone Peer Review Organization, Inc.
777 East Park Drive
P.O. Box 8310
Harrisburg, PA 17105-8310
1-800-322-1914 (in-state only)
717-564-8288

PUERTO RICO
Puerto Rico Foundation for Medical Care
Suite 605 Mercantile Plaza
Hato Rey, PR 00918
1-809-753-6705* or 1-809-753-6708*

RHODE ISLAND
Health Care Review, Inc.
Henry C. Hall Building
345 Blackstone Boulevard
Providence, RI 02906
1-800-221-1691 (New England-wide)
(in Rhode Island dial 1-800-662-5028)
1-401-331-6661*

SOUTH CAROLINA
Carolina Medical Review
101 Executive Center Drive
Suite 123
Columbia, SC 29210
1-800-922-3089 (in-state only)
803-731-8225

SOUTH DAKOTA
South Dakota Foundation for Medical Care
1323 South Minnesota Avenue
Sioux Falls, SD 57105
1-800-658-2285

TENNESSEE
Mid-South Foundation for Medical Care
Suite 400
6401 Poplar Avenue
Memphis, TN 38119
1-800-873-2273

TEXAS
Texas Medical Foundation
Barton Oaks Plaza Two, Suite 200
901 Mopac Expressway South
Austin, TX 78746
1-800-725-8315 (in-state only)
512-329-6610

UTAH
Utah Peer Review Organization
675 East 2100 South
Suite 270
Salt Lake City, UT 84106-1864
1-800-274-2290

VERMONT
New Hampshire Foundation for Medical Care
(PRO for Vermont)
15 Rollinsford Road, Suite 302
Dover, NH 03820
1-800-639-8427 (in Vermont only)
1-802-655-6302*

VIRGIN ISLANDS
Virgin Islands Medical Institute, Inc.
IAD Estate Diamond Ruby
P.O. Box 1566
Christiansted
St. Croix, U.S., VI 00821-1566
1-809-778-6470*

*PRO will accept collect calls from out of state on this number.

MEDICARE PEER REVIEW ORGANIZATIONS (PROs)

PROs can answer questions about hospital stays and other Hospital Insurance (Part A) services. Do not call the PRO with questions about Medicare Medical Insurance (Part B).

VIRGINIA
Medical Society of Virginia Review Organization
1606 Santa Rosa Road, Suite 235
P.O. Box K 70
Richmond, VA 23288
1-800-545-3814 (DC, MD and VA)
804-289-5320
(in Richmond, dial 289-5397)

WASHINGTON
Professional Review Organization for Washington
Suite 100
10700 Meridian Avenue, North
Seattle, WA 98133-9008
1-800-445-6941
(in Seattle, dial 368-8272)

WEST VIRGINIA
West Virginia Medical Institute, Inc.
3001 Chesterfield Place
Charleston, WV 25304
1-800-642-8686, ext. 266
(in Charlestown, dial 346-9864)

WISCONSIN
Wisconsin Peer Review Organization
2909 Landmark Place
Madison, WI 53713
1-800-362-2320 (in-state only)
608-274-1940

WYOMING
Montana-Wyoming Foundation for Medical Care
400 North Park, 2nd Floor
Helena, MT 59601
1-800-826-8978 (in Wyoming only)
1-406-443-4020*

*PRO will accept collect calls from out of state on this number.

States with assignment laws

Connecticut:
Connecticut Department of Aging
CONNMAP
175 Main Street
Hartford, CT 06106
1-800-443-9946 *
(203) 566-7772

Massachusetts:
Executive Office of Elder Affairs
1 Ashburton Place
Boston, MA 02108
1-800-882-2003 *
(617) 727-7750

New York:
State Office for the Aging
2 Empire State Plaza
Albany, NY 12223
1-800-342-9871 *
(518) 474-5731

Ohio:
Department of Health
246 North High Street
Post Office Box 118
Columbus, Ohio 43266-0118
1-800-686-1578*
(614) 466-2070

Pennsylvania:
Department of Aging
Market Street State Office Bldg.
400 Market Street
Harrisburg, PA 17101
(717) 783-8975

Rhode Island:
Department of Elderly Affairs
160 Pine Street
Providence, RI 02903-3708
1-800-322-2880 *
(401) 277-2880

Vermont:
Department of Aging and Disabilities
103 South Main Street
Waterbury, VT 05676
1-800-642-5119*
(802) 241-2400

* These numbers are toll-free within the state.

INDEX

Address lists
  Medicare carriers, 39-44
  Peer Review Organizations, 45-49
Advance directives, 4
Ambulance services, 25
Ambulatory surgical services, 23
Annual Part B deductible, 21, 38
Antigens, 27
Appeal rights, 35
Appealing claims decisions
  by carriers, 35
  by health maintenance organizations, 36
  by intermediaries, 35
  by Peer Review Organizations, 35
  by providers of Part A services, 35
Appliances. *See* Medical appliances.
Application process, 3
Approved charges, 29
Assignment payment method, 28
Assistance for low-income beneficiaries, 2-3

Benefit periods
  hospice care, 19
  hospital and skilled nursing facility, 14
Black lung benefits, 10
Blood
  deductible amount, 16, 21, 37, 38
  hemophilia clotting factors, 27
  home health care, transfusions, 19
  hospital inpatient, transfusions, 15
  hospital outpatient, transfusions, 23
  skilled nursing facility, transfusions, 18
Breast cancer screening, 25
Buying Medicare, 1, 33

Cancelling Part B, 33
Care not covered, 12
Certified registered nurse anesthetist, 23
Certified nurse midwife, 23
Charge limits, 26, 28, 29, 37
Chiropractors, services covered, 22
Christian Science sanatorium, 16
Claim number, 2
Claims
  benefits explanation notice, 31
  claim number, 2
  deceased beneficiary, 32
  insurance other than Medicare, 8-11
  intermediaries' and carriers' role, 3
  Railroad Retirement system, 1, 2
  submission, for home health care, 18
  submission process, 29-30
  time limit, 32
Clinical nurse specialists, psychologists,
  social workers, 23
CMPs. *See* Coordinated health care organizations.
Coinsurance, 1, 15, 17, 21, 37, 38
Competitive medical plans (CMPs).
  See Coordinated health care organizations.
Complaints
  fraud and abuse hot line, 5
  Medigap fraud, 9
  review process, 3
  skilled nursing facility, 17
Comprehensive Outpatient Rehabilitation
  Facility (CORF), 24
Coordinated Health Care Organizations
  (HMOs, CMPs)
  appealing decisions, 35
  enrollment and coverage, 6-7
  fraud, 4
  quality of care, 6-7
Cosmetic surgery, 22
Counseling, 19, 20, 24
Custodial care, 12, 17

Data matching, 5, 11
Deductibles
  annual, Part B, 21, 38
  blood, 16, 21, 37, 38
  hospital insurance (Part A), 15, 33
  medical insurance (Part B), 21, 38
Dentists, services covered, 22
Diagnosis Related Groups (DRGs), 16
Diagnostic tests, 25
Dialysis. *See* Kidney disease.
Disabled people
  cancelling or losing Medicare protection, 34
  eligibility for coverage, 1
  employer health plans, 10
  enrollment process, 2, 33

Doctors
participating, 28
services covered, 21-22
Doctors of osteopathy, 22
DRGs. *See* Diagnosis Related Groups.
Drugs and biologicals
coverage under Part A, 15, 18, 19
coverage under Part B, 22,23,27
hemophilia clotting factors, 27
hepatitis B vaccine, 27
immunosuppressive drugs, 27
influenza vaccine, 27
pneumococcal pneumonia vaccine, 26
Durable medical equipment
coinsurance for, 19
description, 26
oxegyn, 26
Durable power of attorney for health care, 4

Elective surgery, written estimate of costs, 29
Emergency room services, 23
Enrollment, Medicare cards, 2
Enrollment process
hospital insurance (Part A), 2, 33
medical insurance (Part B), 2, 33
Epoetin alfa, 27
Equipment. *See* Durable medical equipment; Medical appliances.
Explanation of Your Medicare Part B Benefits, notice, 31
Eye examinations, 22

Fee schedule, 28, 29
Federally qualified health center, 24
Financial assistance for
low-income beneficiaries, 2-3
Foot care, 22
Foreign hospital care, 16
Fraud and abuse, 4-5, 9

HCFA 1500, form, 30
Health maintenance organizations (HMOs). *See* Coordinated health care organizations.
Heart transplants, 25
Hemophilia clotting factors, 27
Hepatitis B vaccine, 27
HMOs. *See* Coordinated health care organizations.
Home health agencies, 18
Home health aides, 19
Home health care
Part A coverage, 18
Part B coverage, 24
Homemaker services, 18, 19
Hospice care
and coordinated health care organizations, 6
description, 19
services covered, 19, 20
Hospital inpatient care
blood, payment for, 16, 37
Christian Science sanatorium, 16
conditions for payment, 14-15
deductible and coinsurance, 15
foreign hospitals, 16
psychiatric, 16
reserve days, 15
services covered/not covered, 15
Hospital insurance (Part A)
appealing decisions, 35
benefit periods, 14, 17, 19
buying, 1-2, 33
cancelling or losing protection, 34
coinsurance, 14, 17, 37
coverage, 14-20
deductible, 15, 37
eligibility, 1
enrollment process, 2, 33
noncoverage, notice of, 35
patient rights, 5, 6-7, 35
premiums, premium-free, 1, 3, 33
prospective payment system, 16
Hospital outpatient care, 23
Hot line, fraud and abuse, 4-5
Medigap fraud, 9

Immunizations, 26
Immunosuppressive drugs, 27
An Important Message From Medicare, 3
Inpatient care, hospital. *See* Hospital inpatient care.
Insurance. *Also see* Hospital insurance (Part A); Medical insurance (Part B).
illegal sales practices, penalties and fines, 9
other than Medicare, claims submission, 10-11
supplemental, 8-9
Intermediaries and carriers
appealing decisions by, 35-36
description, 3

Kidney disease
cancelling or losing Medicare protection, 34
and coordinated health care organizations, 6
coverage booklet, 25, 34
dialysis and transplants, 25
Medicare as secondary payer, 10-11

Laboratory services
doctor's office, independent, hospital outpatient, 25
hospital inpatient, 13
Limitation of liability, 12-13
Limits to physician charges, 28-29
Liver transplants, 25
Living wills, 4
Low-income assistance, 2-3

Mammography screening, 25
Managed care. *See* Coordinated health care organizations.
Medical appliances
hospice care, 20
inpatient care, 15
skilled nursing facility, 18
Medical insurance (Part B)
appealing decisions, 35
approved charges, 29
assignment payment method, 28
benefits explanation notice, 30-31
buying, 1-2, 33
cancelling or losing protection, 34
claims, 28-30
coverage, 21-27
deductible and coinsurance amounts, 28-29, 37
doctors and suppliers, participating, 28
eligibility, 1
enrollment process, 2, 33
premium amount, 37
providers, participating, 28
Medical supplies, 15, 18, 20, 26
description, 26
Medicare, Part A. *See* Hospital insurance (Part A).
Medicare, Part B. *See* Medical insurance (Part B).
Medicare cards, 2
Medicare Participating Physician/Supplier Directory, 28
Medicare secondary payer, 10-11
Medicare SELECT, 8-9
Medigap insurance
buying, 8-9
fraud, hotline, 9
Mental illness, outpatient treatment, 27

Noncoverage
notice of, 34
what Medicare does not cover, 15-16, 18, 19, 20
Notice of Utilization, 12, 32
Nurse anesthetists, midwives, practitioners, and specialists, clinical, 23
Nursing home. *See* Skilled nursing facility.

Occupational therapy. *See* Therapy.
Open enrollment period, Medigap, 8
Optometrists, services covered, 22
Osteopathy, doctors of, 22
Outpatient hospital, services covered/not covered, 23
Oxygen equipment. *See* Durable medical equipment.

Pap smears, 25
Part A. *See* Hospital insurance (Part A).
Part B. *See* Medical insurance (Part B).
Partial hospitalization for mental health treatment, 24
Participating doctors and suppliers, 28
Participating providers, 29
Payments. *Also see* Deductibles.
assignment payment method, 28
for blood. *See* Blood.
limitation of liability, 12
overpayments, 23
Part A, 15
prospective payment system, 16
Peer Review Organizations (PROs)
address and telephone number list, 45-49
appealing decisions, 4, 35
complaints review process, 3-4
description, 3
Physical examinations, routine, 22
Physical therapy. *See* Therapy.
Physician assistants, 23
Physicians
participating, 28
services covered, 21-22
Pneumococcal pneumonia vaccine, 27

Podiatrists, services covered, 22
PPS. *See* Prospective payment system.
Premium-free eligibility, 1
Premium, Part A, 1, 33, 37
Premium, Part B, 1, 33, 38
Prepaid health care organizations.
See Coordinated health care organizations.
Prescription drugs. *See* Drugs and biologicals.
Privacy Act, 5
Private duty nurses, 15, 18
Private insurance organizations, 10-11
Also see Intermediaries and carriers.
PROs. *See* Peer Review Organizations.
Prospective payment system (PPS), 16
Prosthetic devices, 26
Providers, payment of, 14, 29
Psychiatric care. *Also see* Mental illness.
psychiatric hospital care, 16
Psychologists, clinical, 23

Qualified Medicare Beneficiary, 2-3
Quality of care. *Also see* Peer Review Organizations.
complaints, 4
fraud and abuse hot line number, 4-5

Radiation therapy, 25
Reasonable and necessary care, 12
Rehabilitative services. *See* Therapy.
Relatives, services by, 12
Reserve days, 15
Respiratory therapy. *See* Therapy.
Respite care, hospice, 19
Routine physical examinations, 22
Rural health clinic services, 24

Seat lift chairs. *See* Durable medical equipment.
Second opinion before surgery, 22
Secondary payer, 10-11
Services not covered, 12-13
Skilled nursing facility
inpatient care, 17-18
services covered/not covered, 15-16
Social Security Administration
disability eligibility, 1
enrollment, cards, premium amounts, questions, 1-2
Social worker, clinical, 23
Special enrollment period, 33
Special practitioners, 23
Speech pathology, 15, 20
Speech therapy. *See* Therapy.
State survey agency, 18
Supplemental insurance. *See* Medigap insurance.
Supplies. *See* Medical supplies.
Surgery
ambulatory, 23-24
cosmetic, 22
elective, 22, 29
second opinion, 22

Telephone numbers, toll-free
Cancer information, 25
hot line, fraud and abuse, 5
Medicare carriers, 39-44
Medigap, fraud, 9
Peer Review Organizations, 45-49
second opinion, referral, 22
Terminal illness. *See* Hospice care.
Tests, diagnostic, 25
Therapy
Comprehensive Outpatient Rehabilitation Facility services, 24
doctors' services, coverage, 21
home health care, coverage, 19
hospice care, coverage, 20
inpatient, coverage, 15
occupational, 15, 18, 19, 20, 24
outpatient, coverage, 24
physical, 15, 18, 19, 20, 24
radiation, coverage, 15, 25
respiratory, 24
skilled nursing facility, coverage, 18
speech, 18, 24
Time limit for claims submission, 29-30
Toll-free telephone numbers.
See Telephone numbers.

Vaccines, 26
Veterans benefits, 10-11

Waiver of liability, 12-13
Wheelchairs. *See* Durable medical equipment.
Workers' compensation benefits, 10

X-ray services, 15, 25

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